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POLICY CHOICES FOR LONG-TERM CARE

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NOTES

Unless otherwise indicated or clear from the context, all years referred to in the text are calendar years.

Details in the text, tables, and figures of this study may not add to the totals because of rounding. Similarly, percentages reported in the text and tables may differ from those implied by the reported levels of variables because the reported levels have been rounded.

PREFACE

In response to a request from the Committee on the Budget of the House of Representatives, this study analyzes policy choices for long-term care. In particular, it addresses the projected growth in total and federal spending on long-term care under current law. It also examines alternative ways to increase financial protection for people who require extensive care and to broaden the range of services available to them.

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SUMMARY

Financing long-term care (LTC) services presents policymakers with a dilemma because the various goals of policy that many see as desirable are inherently inconsistent. In particular, containing the burgeoning total costs of LTC that are anticipated under current policies conflicts with providing better protection for LTC users against the out-of-pocket costs of this care, broadening the range of services available, and improving their quality.

Total LTC expenditures, and the amount that federal taxpayers fund under current law, are projected to rise rapidly because of the aging of the baby-boom generation, improvements in life expectancy, and rates of price increase for LTC services that exceed general inflation. Although medical research may be able to reduce future care requirements by finding ways to prevent the need for care, the policy dilemma will remain.

Some observers--"fiscal critics" of the present system--consider that both the level and expected growth rate of federal LTC costs are unacceptably high and that the private sector should therefore play a larger role in financing LTC services. Other observers--"performance critics" of the present system--consider that the system provides too little financial protection for people who need extended and, in many cases, very costly LTC services. They also want a broader range and higher quality of services to be available. Yet policy changes that would expand access to services and reduce the financial burden on individuals requiring them would in general increase total expenditures. Most changes would also raise federal outlays--perhaps by billions of dollars annually--beyond the increases projected under current law.

BACKGROUND

Long-term care services are rehabilitative, medical, and supportive social services of various kinds for people who have functional limitations or chronic health conditions and who need ongoing health care or assistance with normal activities of daily living. These services include nursing home care and a range of home- and community-based (H&CB) services.

Although most people who need LTC receive it in the form of unpaid care from family members and friends, paid services are a big business that amounted to nearly $58 billion in fiscal year 1988 (see Summary Table 1). As the baby-boom generation ages, the LTC business will grow (see Summary Figure 1 for projected use of the principal form of care). Governments already pay half the total cost, mainly through the Medicaid program, and face the prospect of rapid growth in spending under current policy. Moreover, the prospects for avoiding the projected increases in federal outlays are bleak because the most effective mechanisms for doing so are already in place: individuals are now required to exhaust most of their own resources before receiving publicly subsidized care, the range of subsidized services is narrowly defined, and the states are already required to share in the costs of the Medicaid programs that they administer.

Complicating the challenge for policymakers is that the nature of the alleged problem of access to services in the current system is unclear. Despite anecdotal accounts of shortcomings in available LTC, there is little reliable quantitative evidence from nationwide studies showing that significant numbers of people fail to receive needed assistance. This dearth of evidence could imply that no real problem with shortages of LTC or unmet needs for LTC exists; it might, on the other hand, simply reflect a lack of consensus on what constitutes a "shortage" or on what is "needed" or "adequate" care. Finally, concerns about access might be of a quite different kind--reflecting, for instance, dissatisfaction with the financial terms on which access is currently available, or subjective evaluations of the scale, appropriateness, quality, or flexibility of care under the present system. Regardless of the nature of the access problem, however, a clear trade-off exists between modifying the LTC system to reduce individuals' financial vulnerability and the public and private costs of doing so.

SUMMARY TABLE 1. ESTIMATED TOTAL SPENDING ON LONG-TERM CARE SERVICES BY TYPE OF SERVICE AND SOURCE OF PAYMENT, FISCAL YEAR 1988 (In billions of dollars)

Payment Source	Nursing Home Care[a]	Home- and Community-Based Care[b]	Total
Total	44.3	13.6	57.8
Federal	13.3	5.0	18.3
Medicare	0.9	2.4	3.3
Medicaid	11.5	1.3	12.9
VA and other[c]	0.9	1.2	2.2
State and Local	9.5	2.6	12.1
Medicaid	9.4	1.1	10.5
Other[d]	e	1.5	1.6
Private	21.5	6.0	27.5
Out-of-pocket	20.2	5.1	25.3
Health insurance	f	0.2	0.2
Other[g]	1.3	0.7	1.9

SOURCE: Congressional Budget Office calculations based on estimates from Actuarial Research Corporation.

NOTE: VA = Department of Veterans Affairs.

a. Nursing home care includes services provided in skilled nursing facilities, intermediate care facilities, combinations of skilled and intermediate nursing facilities, intermediate care facilities for mentally retarded people, and noncertified facilities providing some nursing care.

b. Home- and community-based care includes nursing care, speech therapy, physical therapy, occupational therapy, services provided by home health aides and homemakers, medical social services, home-delivered and center-based meals, adult day care, senior centers, and transportation services.

c. Federal payments for home- and community-based care services are also provided under the Older Americans Act and the Social Services Block Grant.

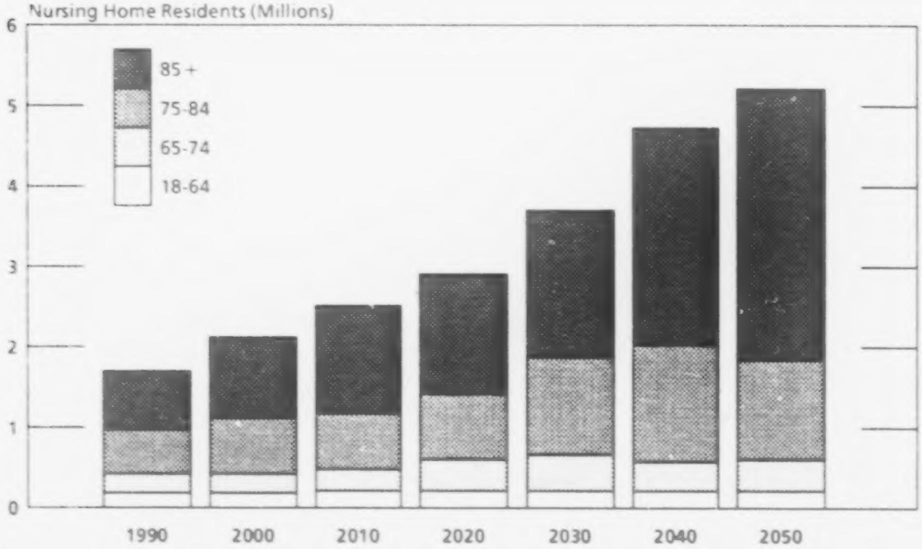
d. Other state funding includes Medicaid-related payments for which there was no federal matching and funding from state general revenues.

e. Less than $50 million.

f. Not separately identified. Included with "other private."

g. Other private sources of payment include private organizations and, for nursing home care, private insurance.

Summary Figure 1.
Projected Number of Nursing Home Residents, by Age of Resident and Year



SOURCE: Congressional Budget Office calculations based on middle series projections in Bureau of the Census, Current Population Reports, series P-25, no. 1018 (January 1989).

NOTE: The calculations assume that age-specific rates of use of nursing home beds will remain at 1985 levels.

ISSUES

Long-term care policy might have several goals. It could aim to:

- Ensure that services are available, whether or not the people needing them can pay for them;
- Ensure that these services are of satisfactory quality;
- Protect individuals needing services against their potentially catastrophic costs; and

- Avoid unnecessary federal outlays and contain their aggregate level.

People disagree, however, about the priority of these goals relative to other urgent fiscal concerns--not the least of which is reducing the federal deficit--and relative to one another. What weight, for example, should be given to the goal of providing financial protection against LTC costs? The Medicaid program is designed to address the goal of making LTC services available, but generally provides little protection for people's own resources because they remain ineligible until they have spent all but defined amounts of their resources on care.

Issues Relating to Financial Protection for Individuals

Policymakers who wished to extend financial protection against the catastrophic costs of LTC would need to make four sets of choices in designing policies to do so. These choices concern the mechanism for providing financial protection, the range of services to be covered, the specific groups to be targeted for public assistance, and the division of responsibility between the public and private sectors and among the levels of government.

Selecting a Mechanism for Providing Financial Protection. The first choice would be to decide among alternative methods for providing protection against the high costs of LTC. Possible mechanisms include encouraging greater personal saving, establishing risk-pooling arrangements, providing subsidies that would be related to people's resources, or combining these strategies.

- Incentives to save are intended to augment personal resources and so to promote self-sufficiency in purchasing needed LTC services. These incentives, though, appear more likely to increase the net cost of LTC to the public sector than to reduce it.

- Risk-pooling arrangements would involve generally available insurance or prepaid care mechanisms through which nonusers and users of services at all income and asset levels could share the financial risks associated with LTC use. Unregulated private markets for LTC insurance, however, appear subject to market failure in ways that result in too little coverage.

- Resource-related subsidies, if used alone, would make LTC services available at subsidized prices for people with limited resources. A policy on user charges would specify how price subsidies would relate to the number of services used, the cost of each service, and the individual's level of privately available resources. The subsidies, however, would normally be financed by taxpayers.

- These three strategies could also be combined in various ways. In particular, combining risk-pooling arrangements with resource-related subsidies would create the option of subsidizing the participation of low-income people in any risk-pooling arrangements established for LTC. Subsidies for risk-pooling arrangements would also be borne by taxpayers.

Selecting the Services to be Covered. The second choice relates to the range of services for which financial protection would be offered. At issue are questions of balance within the overall mix of LTC services: balance between residential and nonresidential forms of care--for example, whether financial protection would be provided against the costs of all LTC services, or only nursing home care; balance within residential forms of care among nursing homes and other types of facilities that offer supportive or therapeutic care in a less restrictive setting; and balance within nonresidential forms of care among various in-home and community-based services.

Concerning the balance between residential and nonresidential forms of care, the critical policy question is the extent to which society is prepared to offer financial protection against the costs of H&CB care that may increase the quality of life for frail and functionally dependent people and their unpaid caregivers. This question is crucial because the evidence suggests that expanding conventional H&CB

programs would not reduce aggregate public LTC expenditures and could increase them considerably.

Targeting Assistance. The third choice concerns the specific groups toward whom public funds would be targeted if limitations on funding made such targeting the preferred approach. The possible criteria for defining target groups include age, duration of the need for services, the level of functional limitations, and the level of private resources available to LTC recipients or their families.

Assigning Responsibilities Within the LTC System. The fourth choice concerns how to divide responsibility within the LTC system among the private sector, state and local governments, and the federal government. Relevant areas of responsibility include determining the features of the LTC system, administering the system, and financing the paid care that is provided.

Issues Relating to Total and Federal Costs

Virtually any LTC policy changes that would reduce financial vulnerability could be expected to increase total expenditures for LTC. They could also be expected to increase either federal outlays for LTC or the federal revenue losses associated with tax preferences for private LTC expenditures.

Policy changes to improve financial protection under voluntary arrangements would need either to increase the private resources available to purchase LTC services or to reduce the out-of-pocket cost of using services (which is the effective price of these services). Measures that would increase private resources--for example, tax incentives for private saving dedicated to LTC services--would probably reduce federal revenue by more than they would reduce Medicaid outlays. Measures that would reduce the out-of-pocket cost of using services would lead people to change--and in many cases to raise--the amounts, kinds, and quality of services they used in ways that would increase overall costs.

Increased private resources and lower effective prices for services would each increase use. If the supply of LTC services expanded less quickly, at least in the short run, then their prices would rise as well. Both effects would directly increase total costs and governmental costs. In addition, there could be indirect effects on costs. Attitudes toward the acceptability of paid LTC services might change, further increasing their use and cost, although the magnitude of these behavioral changes is unpredictable. Moreover, if accepted standards of care also rose, Medicaid would be expected to meet them, thereby indirectly increasing federal and state expenditures.

Proposals to improve financial protection need not expand the relative role of the federal government, however, although the absolute level of federal outlays or revenue losses would probably rise. For example, the federal government could continue to share program costs with the states in the same proportions as at present.

Historically, it appears that most growth in Medicaid's real spending on nursing home care has reflected growth in the number of days of nursing home care for which Medicaid paid rather than real growth in the cost of a day of care. In turn, growth in the number of nursing home days of care for which Medicaid paid appears to have resulted more from growth in days of care per recipient than from growth in the number of recipients.

OPTIONS

Two broad approaches to modifying the LTC system are possible. One approach would retain both the current division of responsibility for LTC and Medicaid's basic character as an income-tested and asset-tested program. It would address specific problems in the design of the Medicaid program through changes that could be implemented incrementally, depending on priorities and the availability of funds. The other broad approach would more fundamentally restructure the systems for financing and delivering long-term care. In the process, it would substantially modify the division of responsibility for that care.

Numerous options are available under each approach. The Summary Box classifies many of these options by the extent and type of changes they would make in responsibilities within the LTC system.

Incremental Options

Five illustrative options for changes in Medicaid would address various goals of LTC policy. Two of the options would increase both the availability of services and financial protection against their costs by establishing medically needy programs in all states and by broadening the availability of H&CB services for severely dependent people. Two additional options are designed to help contain net public outlays for LTC. One would tighten estate-recovery processes. The other would incorporate two approaches, whose effectiveness in containing program costs has been asserted but remains unproven. This option would regulate growth in the number of nursing home beds eligible for federal funding and extend the requirement for preadmission screening to a wider group of nursing home applicants. The remaining option could make a modest contribution to enhancing the quality of life for residents in nursing homes by raising and indexing the personal needs allowance, which enables Medicaid-eligible nursing home residents to make limited personal purchases.

Overall, these illustrative options could provide increased financial protection for a broader range of services, could make this protection more uniform across the states, and might increase the quality of life for some people needing LTC services. They would do so, however, at additional cost to taxpayers, and they would in some respects restrict the freedom of states to experiment and to determine the scope and structure of Medicaid in light of local conditions and values. They would also include features designed to contain costs that might prove ineffective or inimical to promoting both access and quality.

SUMMARY BOX
Illustrative Policy Options for Long-Term Care

Implement Incremental Changes Within Medicaid

- Mandate medically needy programs for LTC services.
- Expand the availability of home- and community-based services for severely dependent people.
- Tighten estate-recovery processes and rules.
- Mandate state regulation of growth in the number of nursing home beds and preadmission screening for additional nursing home applicants.
- Raise and index the personal needs allowance.

Expand Role of Private Sector

- Introduce a refundable income tax credit for expenditures on private LTC insurance.
- Require employers to arrange community-rated group LTC insurance coverage for employees and their family members and require employees to purchase it, possibly with a subsidy from employers or taxpayers.
- Change the tax treatment of retirement income and insurance plans to facilitate combined insurance against the needs for retirement income, LTC, and income for survivors.

Expand Role of State Governments

- Replace current federal LTC expenditures with an indexed block grant and transfer most policy and administrative responsibility for LTC to the states.
- Replace current federal LTC expenditures with a block grant designed to grow in real terms and to help finance a state-administered system of case-managed care that would satisfy federal guidelines.

Expand Role of Federal Government

- Establish social insurance offering comprehensive coverage.
- Establish social insurance covering an initial period of care ("front end").
- Establish social insurance covering care after an initial period ("back end").
- Establish social insurance covering people with assets below the median level.
- Establish social insurance covering nursing home care only.

Options that Would Substantially Modify the Division of Responsibility for Long-Term Care

Options that would more fundamentally restructure the financing and delivery of LTC can be grouped into three strategies. In essence, these strategies would expand the roles of the private sector, of the states, and of the federal government, respectively.

Expand the Role of the Private Sector. One strategy would provide public subsidies or regulatory support for participation in LTC financing arrangements that are under private auspices. This strategy would make greater use of the private sector--in providing or channeling funds to pay for services supplied by private organizations--but it would not necessarily reduce taxpayers' costs and could increase them. It could include subsidizing either private LTC insurance or private saving for LTC, while retaining a residual welfare program for people unable to secure needed care because they were poor or were denied insurance coverage on health grounds.

A refundable income tax credit for private LTC insurance, for example, would represent a flexible policy option that could substantially increase financial protection for those purchasing coverage and that might appreciably reduce Medicaid costs in the long run, although not necessarily by more than it would reduce tax revenues. Subsidizing private insurance for individuals, however, would not assist people with preexisting conditions that imply a current or future need for LTC, and it could require considerable regulation of the LTC insurance industry (which has yet to demonstrate either long-term commercial viability or large-scale consumer appeal). Moreover, the level of public subsidies--and hence of public expenditures--that would be required to achieve widespread insurance coverage under the option would almost certainly be large but cannot be quantified precisely.

Another option would require employers to arrange coverage for most employees and their family members under a community-rated, group LTC insurance policy with a standard package of vested, prefunded, indexed benefits that could be preserved by people leaving employment. Employees could be required to pay premiums from after-tax income with no public subsidy, or employees' premium payments could qualify for a refundable income tax credit as in the previous option, or any employer contributions could receive a degree of tax preference similar to that for employer pension contributions. This option could progressively establish widespread LTC insurance coverage. Because premiums would be community-rated, no one could be denied coverage because of preexisting conditions. Coverage would be achieved, however, by compelling LTC insurers to offer such coverage, employers to sponsor it, and employees to purchase it. Also, the federal government might in practice become the reinsurer of last resort, assuming ultimate financial liability if the insurance arrangements collapsed.

The illustrative option to promote saving for LTC, which can also be thought of as self-insurance, would make it easier for people to accumulate contingent assets (those that become available to their owners in defined circumstances). The option would change the tax treatment of retirement income and insurance plans to permit combined insurance against the needs for retirement income, LTC, and income for survivors. It would thus integrate private saving for LTC with the broader system of private saving for retirement income support. Cash benefits in the integrated system would then reflect health-induced variations in financial need among retirees. Providing benefits in cash, however, might lead to increased demand, more rapid growth in LTC prices, and cash payment for care that is currently unpaid. Moreover, information on which to base the levels of benefits and premiums in an integrated system is quite limited.

Expand the Role of the States. A second strategy would involve providing LTC block grants to the states in place of current federal LTC funding under Medicaid, Medicare, and portions of the Older Americans Act and the Social Services Block Grant. To qualify for the grants, state LTC programs would need to satisfy certain federal conditions. This option is compatible with a broad range of levels of federal financial commitment and policy responsibility for LTC. Federal funding under this option could vary from its present level, indexed only for inflation, to levels determined by a formula that could reflect the age structure of a state's population--for example, by incorporating progressively higher capitation rates for successively older cohorts--as well as the state's average per capita income. Similarly, conditions of the grant could vary from a mere requirement that states maintain their current inflation-adjusted funding levels for LTC to extensive provisions that would specify the minimum scope of coverage or requirements for LTC delivery systems.

This strategy would impose a predictable ceiling on federal outlays for LTC and would permit real growth in these outlays to be contained as desired. Some options under this strategy could dramatically lower federal costs compared with current law, but in doing so they would either transfer these costs to the states at a time when the population requiring LTC is expected to balloon or increase the costs being borne by those using LTC services and their families. Other options that involved higher levels of federal funding would enable the federal government to limit its outlays but retain significant influence over LTC policy. States might fear, however, that the federal financial commitment would be reduced after they had accepted greater financial, policy, and administrative responsibility for future systems of LTC.

Expand the Role of the Federal Government. A third strategy would involve a new social insurance program that would provide a legislatively based entitlement to defined LTC services for individuals assessed as having specified functional limitations. The most comprehensive option under this strategy would provide a full range of needed services to all people qualifying for the entitlement. Other options would adopt differing criteria to limit the scope of coverage and thus the implied increase in federal LTC costs. These criteria could limit coverage based on the duration of care (for example, covering only the "front end" or "back end" of care), the asset level of the care recipient (for example, covering only people with assets below the median level), or the type of care required (for example, covering only nursing home care).

By creating a new social insurance program, this strategy would spread the financial risks associated with the use of covered LTC across the whole population and would thereby provide a high degree of financial protection against the costs of this care. This approach would integrate not only the financing of LTC, but possibly also its delivery, and would provide all eligible people throughout the country with a similar opportunity to receive needed care.

The major drawback is that total federal LTC outlays would be much higher than under current law: more people needing LTC would qualify for assistance; a larger share of the services they received would be federally financed; people would seek more services than if they were paying fully for the care themselves; and the increase in demand could raise the unit price of LTC services. Moreover, assessment processes that were developed for research and clinical purposes, rather than as administrative criteria for determining an entitlement to benefits, would have a primary role in determining not only each individual's entitlement but also total spending on the program. People needing costly LTC services might characterize their problems more seriously to assessors who controlled access to the desired services. As a result, the number of people assessed as eligible for services under the entitlement could increase to an unknown degree. Consequently, public-sector costs under this strategy--especially for H&CB care--would not only be high but would also be subject to significant uncertainty.

CHAPTER I

BACKGROUND

Spending on long-term care (LTC) services primarily for people with chronic illnesses or functional limitations totaled an estimated $57.8 billion in fiscal year 1988. Under current financing arrangements, some analysts project that such spending could triple over the next three decades, even after adjusting for general inflation.[1] The aging of the baby-boom cohort, improved longevity, and the prospect of price increases for labor-intensive services that exceed general inflation together imply that, for several decades, a greater share of total spending--and also of federal spending--will be directed toward LTC if the public role in financing services and current patterns of use remain broadly unchanged. Nevertheless, despite the projected growth in federal costs, concern is frequently voiced that paying for LTC services places an excessive financial burden on many individuals and families. As a result, various proposals have been advanced to reduce the financial burden on users by restructuring LTC financing.

OVERVIEW OF THE POLICY DEBATE ON LONG-TERM CARE

A lively policy debate has emerged over how to finance nursing home care and other LTC for people with chronic illnesses or functional limitations. This debate is likely to continue in the years ahead not only because demand will grow substantially but also because at its heart are conflicting perspectives on policy. Critics of the LTC system divide roughly into two groups--"fiscal" critics and "performance" critics. The focus of the debate--and the basic dilemma for policy--is whether, and if so how, to respond to their divergent prescriptions for change.

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1. A.M. Rivlin and J.M. Wiener, *Caring for the Disabled Elderly* (Washington, D.C.: Brookings Institution, 1988), p. 28.

Fiscal critics note that total public and private spending for nursing home and home health care promises to increase sharply until well into the next century, largely because the very old population is expected to grow rapidly. Fiscal critics believe public expenditures on LTC are already too high, both in absolute terms and relative to what is being achieved. In their view, demographic trends can only make things worse by dramatically increasing both total LTC costs and public costs under current law. Fiscal critics want individuals and their families to retain primary responsibility for providing or paying for LTC, the private sector to play an expanded role in the financing and delivery of services, and public policy to place greater emphasis on cost containment.

Performance critics of the present system believe that many people who need LTC services currently have too little access to appropriate care and that the system currently places insufficient emphasis on maintaining people's capacity for independent living once the potential of diagnostic and curative care has been fully exploited. They want home- and community-based care services to be more widely and more readily available and also want support or alternatives for informal caregivers once the burden of caregiving becomes unreasonable. They also want people who currently do not need LTC for themselves or their relatives to be freed from anxiety that such care, if it became needed, would be financially catastrophic. Moreover, they want access to services to reflect medical and social need rather than economic status or geographic area, and they prefer that choices among alternative LTC services reflect care requirements rather than differential financing arrangements.

The evidence of interest in LTC financing is abundant. Calls for expanded public financing of LTC services were a recurring theme during debate on the Medicare Catastrophic Coverage Act of 1988, which created the Bipartisan Commission on Comprehensive Health Care, also known as the Pepper Commission. This commission recommended major changes in 1990.[2] Numerous legislative proposals with significant cost implications have been introduced in the Congress. In

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[2] U.S. Bipartisan Commission on Comprehensive Health Care, *A Call for Action*, Final Report, S. Prt. 101-114 (September 1990).

March 1990, the Department of the Treasury published *Financing Health and Long-Term Care*, a study mandated by both the President and the Congress. The Advisory Council on Social Security and a task force within the Department of Health and Human Services are both studying LTC financing.

Most recent proposals to change LTC financing include elements that would reduce the financial vulnerability of people needing these services. Some proposals would expand the federal government's role in financing, whereas others would expand the role of the private sector or would transfer costs from the federal government to state and local governments. The issues raised by these proposals are complex, for they involve many of the issues central to income transfer policy, health care policy, and housing policy.

A major goal of this study is to offer a conceptual framework for analyzing these issues and for evaluating the various proposals for change relative to one another and relative to current policy. Its organization reflects two primary considerations. One is the nature of concerns over the financial vulnerability of those needing LTC services and the extent to which various proposals might alleviate these concerns. The other is how the proposals would affect the level of future federal LTC spending. The trade-offs between reduced financial burdens for individuals and families using LTC and increased federal spending are also examined.

The study does not deal with all the important issues in the LTC policy debate. For example, it focuses primarily on the LTC needs of adults and especially older adults. Also, it discusses only briefly the quality of care, administrative issues, and the potential for achieving more efficient use of health care resources by changing the mix of acute and long-term health care services or by coordinating their financing more closely. In addition, it neither canvasses alternative revenue sources for any program expansions, nor estimates the cost or precise distributional implications of specific proposals.

The remainder of this chapter reviews the current organization of the LTC system. It addresses first the nature of LTC services and outlines who uses them and who provides them. It turns next to how LTC services are currently financed.

LONG-TERM CARE, ITS USERS, AND ITS PROVIDERS

Long-term care comprises a diverse range of services that may involve rehabilitative, medical, social, and housing components. Services may be provided in the person's home (for example, visiting nurse, homemaker, and delivered meals services), in community-based facilities (for example, adult day care and rehabilitation services), or in an institutional setting that is also the person's residence (for example, a nursing home, congregate housing, or a personal care facility).

Those Who Use Long-Term Care

People may need LTC for a range of reasons and for varying durations. Many people require LTC because of disabling physical conditions that limit their capacity to perform independently certain "activities of daily living" (ADLs) such as bathing, transferring from a bed or chair, dressing, using the toilet, and eating. Others are limited in performing "instrumental activities of daily living" (IADLs)--common requirements for functioning independently, such as shopping, housecleaning, using the telephone, managing finances, doing laundry, and taking medications correctly. Some people require LTC because they have cognitive disorders (such as Alzheimer's disease or other dementias) or forms of mental illness that interfere with their ability consistently to perform ADLs and IADLs independently. People with permanent conditions may need indefinite help with ADLs, IADLs, or managing chronic medical conditions. Others require similar help while recuperating from acute conditions but then resume their prior lifestyle and level of independence. Among people who have difficulty with ADLs or IADLs, some can nevertheless undertake the activities concerned without assistance and others can manage with the help of special equipment, but the rest must receive either active help or standby help from another person if they are to undertake these activities.[3]

The 1.5 million residents of nursing or personal care homes are disproportionately female, three-quarters require another person's assistance with at least two ADLs, and about 40 percent suffer from dementia. About half display behavioral disorders such as getting upset, yelling, wandering, or physically hurting others.[4]

Although people of all ages need LTC, about three-quarters of functionally disabled adults and 90 percent of nursing home residents are aged 65 or older.[5] The prevalence of disabling conditions and the likelihood of using LTC services both increase with age, especially at ages greater than about 75. For example, about 5 percent of Americans aged 65 or older are nursing home residents on a given day (1.3 percent at ages 65 to 74; 5.8 percent at ages 75 to 84; and 22.0 percent at ages 85 or over).[6] Table 1 shows the proportions of people aged 65 or older who require assistance from another person with ADLs or IADLs.

Although most people admitted to nursing homes have relatively short stays, most nursing home beds are nevertheless occupied by residents whose stays are lengthy. Nursing home residents with short stays account for a larger proportion of total admissions than of either total residents or total days of care because of their relatively high turnover rate--twelve residents each staying one month use the same number of days of care as a single resident staying the whole year. Among people admitted to nursing homes, about 30 percent stay less

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[3] For a discussion of the relative numbers in these groups, see R.I. Stone and C.M. Murtaugh, "The Elderly Population with Chronic Functional Disability: Implications for Home Care Eligibility," *The Gerontologist*, vol. 30, no. 4 (1990), pp. 491-496.

[4] T. Lair and D. Lefkowitz, *Mental Health and Functional Status of Residents of Nursing and Personal Care Homes* (Department of Health and Human Services Pub. No. (PHS) 90-3470), National Medical Expenditure Survey Research Findings 7, Agency for Health Care Policy and Research (September 1990).

[5] Congressional Budget Office calculations based on tabulations from the 1987 National Medical Expenditure Survey.

[6] E. Hing, "Nursing Home Utilization by Current Residents: United States, 1985," Department of Health and Human Services, National Center for Health Statistics, *Vital and Health Statistics*, series 13, no. 102 (1989), Table 2.

TABLE 1. PREVALENCE OF THE NEED FOR ANOTHER PERSON'S HELP WITH PERSONAL CARE ACTIVITIES OR HOME MANAGEMENT ACTIVITIES FOR PEOPLE AGED 65 OR OLDER, BY AGE, PLACE OF RESIDENCE, AND NUMBER OF ASSISTED ACTIVITIES, 1987

Age	Population[a] (Thousands)	Percentage Needing Help with at Least One Personal Care or Home Management Activity	Percentage Needing Assistance, by Number of Personal Care Activities				
			At Least One	One	Two	Three	Four or Five
		Household					
65 or Older	26,517	17.1	8.1	3.6	1.6	1.0	1.9
65 to 69	9,048	8.4	4.2	1.6	1.0	0.5	1.0
70 to 74	7,327	11.7	5.0	1.7	1.2	0.8	1.2
75 to 79	5,096	17.5	8.2	4.7	1.2	0.8	1.5
80 to 84	3,015	30.9	13.4	5.4	3.3	1.7	3.0
85 or Older	2,032	54.8	28.8	13.5	4.3	3.5	7.5
		Nursing or Personal Care Home					
65 or Older	1,370	n.a.	90.2	11.3	11.0	7.5	60.4
65 to 69	84	n.a.	79.9	10.1	15.0	7.3	47.5
70 to 74	111	n.a.	85.6	12.6	13.1	6.4	53.5
75 to 79	203	n.a.	87.5	11.9	10.0	8.9	56.7
80 to 84	279	n.a.	89.3	11.1	10.1	9.6	58.5
85 or Older	693	n.a.	93.4	11.2	10.9	6.3	64.9

SOURCE: Congressional Budget Office based on tabulations provided by the Agency for Health Care Policy and Research from the National Medical Expenditure Survey, Household Survey, Round I, and Institutional Population Component, Phase 1.

NOTES: n.a. = not applicable. Residents of nursing or personal care homes do not perform most home management activities.

Personal care activities, also known as activities of daily living (ADLs), consist of bathing, transferring from a bed or chair, dressing, toileting, and feeding. Home management activities, also known as instrumental activities of daily living (IADLs), consist of using a telephone, handling money, shopping, getting around the community, preparing meals, and doing light housework.

Data from the two panels could be combined to generate estimates of the overall prevalence of the need for help with personal care activities, by number of activities, among those aged 65 or older. Such estimates could be misleading, however. Members of households may have used different criteria than staff in nursing or personal care homes when responding to questions about the need of sample members for personal assistance with ADLs and IADLs.

[a] Includes the civilian population aged 65 or older living either in households or in nursing or personal care homes.

than a month and about half stay less than three months; only one-quarter have stays of at least a year.[7] Among nursing home residents on any given day, however, only 11 percent have been resident for less than three months; 22 percent have been resident for 3 to 12 months, 32 percent for 1 to 3 years, 15 percent for 3 to 5 years, and 20 percent for more than 5 years.[8]

Recent estimates of lifetime nursing home use suggest that, if age-specific rates of use remain unchanged, 43 percent of individuals turning age 65 in 1990--over half of the women and nearly one-third of the men--can expect to use a nursing home sometime before they die. Among couples in which both partners turn 65 in 1990, about seven out of ten can expect that at least one of the two will use a nursing home sometime before death. Those using a nursing home will have an estimated average of 2.8 years of nursing home use--3.2 years for women and 2.1 years for men--between age 65 and death.

When averaged across the entire cohort turning 65 in 1990, expected remaining lifetime nursing home use at age 65 is estimated to be 1.2 years. Because lifetime use varies widely, however, costs of care are distributed quite unequally. For example, 9 percent of the cohort turning 65 in 1990 are expected to use five or more years of care. They represent one-fifth of the users but are expected to account for almost two-thirds of the total costs associated with nursing home care for the cohort. Similarly, the 18 percent of the cohort using two or more years represent less than 45 percent of users but are expected to account for about 90 percent of the costs. In contrast, 57 percent of the cohort could be expected to use no nursing home care at all, whereas the 15 percent with lifetime nursing home use of less than six months, who represent over one-third of all users, are expected to account for just 2 percent of the total costs.[9]

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[7] E.S. Sekscenski, "Discharges from Nursing Homes: 1985 National Nursing Home Survey," Department of Health and Human Services, National Center for Health Statistics, *Vital and Health Statistics*, series 13, no. 103 (1990), Table 2.

[8] See Lair and Lefkowitz, *Mental Health and Functional Status*. This data source records, as a single episode of care, successive periods of nursing home care that are separated only by periods of hospitalization. The previous data source (Sekscenski) may sometimes record each such period of nursing home care as a separate episode. This technical difference, however, accounts for only a small part of the difference in these length-of-stay distributions.

Most participants in adult day care programs are functionally dependent, elderly, white, unmarried women who do not live alone. Almost one-third suffer from a mental disorder. Compared with nursing home residents, however, day care participants are younger, more likely to be married, less dependent, and less frequently mentally impaired.[10]

What Care Is Used and Who Provides It?

In 1986, the United States had 16,388 nursing homes, with an average of 92 beds and an average occupancy rate of 92 percent.[11] About one-fifth of the beds were in homes with 200 beds or more. Of all nursing home beds, 72 percent had proprietary ownership.[12] The proportion of nursing home beds that were in facilities affiliated with chains had grown to about one-half by 1985.[13]

Many people tend to equate LTC with nursing home care. Nevertheless, among aged people who require human assistance with two or more of the five most commonly considered ADLs, at least as many live in the community as live in nursing homes. The majority of aged people requiring human assistance with three or more ADL limitations, however, live in nursing homes (see Table 1).

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[9] C.M. Murtaugh, P. Kemper, and B.C. Spillman, "The Risk of Nursing Home Use in Later Life," *Medical Care*, vol. 28, no. 10 (October 1990), pp. 952-962; P. Kemper and C.M. Murtaugh, "Lifetime Use of Nursing Home Care," *New England Journal of Medicine*, vol. 324, no. 9 (February 28, 1991), pp. 595-600; and P. Kemper, B.C. Spillman, and C.M. Murtaugh, "A Lifetime Perspective on Proposals for Financing Nursing Home Care" (paper presented at the 118th Annual Meeting of the American Public Health Association, October 3, 1990).

[10] W.G. Weissert and others, *Adult Day Care: Findings from a National Survey* (Baltimore: The Johns Hopkins University Press, 1990).

[11] This does not include 734 hospital-based facilities that provided nursing care, or 9,258 residential care facilities that did not provide such care.

[12] Bureau of the Census, *Statistical Abstract of the United States, 1990*, Table 176, p. 112. Data are from the 1986 Inventory of LTC Places.

[13] See Sekscenski, "Discharges from Nursing Homes," Table A, p.4.

Long-term care may be either formal or informal. Formal care denotes paid services or care received through the market; informal care is unpaid assistance given by families and friends of the recipient. Of aged LTC recipients living in the community, about 75 percent receive only informal care, and just 5 percent receive only formal care. Thus the potential for the use of formal LTC to increase is considerable if policy initiatives were to encourage either substituting formal for informal care or reallocating informal caregiving time to different activities focusing on quality of life. In 1982, the average age of informal caregivers--mainly spouses, daughters, and daughters-in-law--was 57; about 36 percent were aged 65 or older. About three-quarters of caregivers lived with the care recipients.[14]

Comprehensive data about the supply of formal home and community-based services are limited.

- There were probably between 6,000 and 8,000 home health agencies in 1983.[15] In 1986, 5,953 home health agencies participated in Medicare.[16] The primary focus of these agencies, however, is skilled medical care for people with acute conditions rather than personal care for people with chronic conditions.

- A total of 980 adult day care centers were identified in 1984.[17] A national survey in 1985-1986 found three broad types of centers that served an average of almost 20 clients per day at a cost of about $30 per participant-day. The three types were centers affiliated with a nursing home or rehabilitation hospital, those affiliated with a general hospital or a social services or housing agency, and those serving a specialized clientele such as people who were blind or mentally ill or veterans.[18]

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[14] R.I. Stone, *Exploding the Myths: Caregiving in America*, U.S. House of Representatives, Select Committee on Aging, Pub. No. 99-611 (January 1987). See also K. Liu, K.G. Manton, and B.M. Liu, "Home Care Expenses for the Disabled Elderly," *Health Care Financing Review*, vol. 7, no. 2 (1985), pp. 51-58.

[15] See Chapter 3 in R.A. Kane and R.L. Kane, *Long-Term Care: Principles, Programs, and Policies* (New York: Springer Publishing Company, 1987).

[16] Department of Health and Human Services, *Health Care Financing Program Statistics: Medicare and Medicaid Data Book, 1990*, HCFA Pub. No. 03314, Table 3.5, p. 40.

[17] N.L. Mace and P.V. Rabins, *Day Care for Demented Adults* (Washington, D.C.: National Institute for Adult Day Care of the National Council on Aging, Inc., 1984).

- National data on the number of respite care services are unavailable, although numerous states are implementing or experimenting with respite care, which is designed to give informal caregivers a break.

HOW IS LONG-TERM CARE CURRENTLY FINANCED?

This section presents estimates of overall spending on LTC and outlines the roles played by the Medicaid, Medicare, and Veterans Affairs programs in financing LTC.

Overall Expenditure on Long-Term Care

Total spending from all sources for LTC in fiscal year 1988 was an estimated $57.8 billion, with nursing home care accounting for 77 percent ($44.3 billion) of this total and home- and community-based (H&CB) care accounting for the remainder ($13.6 billion). (See Table 2 and Tables A-1 and A-2 in the appendix, which describes the data sources and assumptions underlying these estimates.) Payments for these formal LTC services came almost equally from private sources (47 percent) and from federal, state, and local governments (53 percent). Almost all private payments for LTC are made out of pocket by users or their families. Currently, only 4 percent of LTC spending comes from other private sources including insurance. About 40 percent of all people admitted to nursing homes in 1985 initially met its cost primarily from their own private incomes or assets.[19]

Public programs also contribute substantially to LTC financing. Three main federal programs--Medicaid, Medicare, and the health care program of the Department of Veterans Affairs--are involved. Of these, Medicare and Medicaid were established in 1965, largely in response to concerns that older and poor Americans lacked adequate access to acute health care services. Numerous other programs, like the Older Americans Act and the Social Services Block Grant, contribute smaller amounts to LTC financing. State governments are involved not only through the Medicaid program's matching arrangements but also, to a degree that varies significantly across states, through additional commitments of state revenue to state LTC programs.

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[18] See Weissert and others, *Adult Day Care.*

[19] See Sekscenski, "Discharges from Nursing Homes," Table H.

Medicaid

Medicaid, a federal/state welfare program that has become the main public source of LTC funds, finances nursing home care--and to a much lesser extent H&CB care--for people satisfying stringent asset and income standards specified under state or federal law. The federal share of the cost of Medicaid services varied among the states in fiscal year 1990 from 50 percent to 80.2 percent, with the higher federal shares applying where states have relatively low per-capita incomes. Overall, the federal share of total Medicaid spending in fiscal year 1990 was 57 percent.

Eligibility. People may establish financial eligibility for Medicaid assistance with LTC costs in four different ways.

First, aged, blind, or disabled people who participate in the Supplemental Security Income (SSI) program are automatically (or "categorically") eligible for Medicaid assistance in most states. SSI eligibility requires that countable resources--that is, non-exempt assets--be less than $2,000 for an individual and less than $3,000 for a couple. For 1991, countable monthly income must not exceed $427 for an individual or $630 for a couple under the regular federal standard. In the remaining states, known as "Section 209(b) states," SSI participants may have to satisfy more restrictive income or asset standards to qualify for Medicaid. Similarly, people in low-income families who qualify for assistance under the Aid to Families with Dependent Children (AFDC) program automatically are financially eligible for Medicaid-provided LTC services. Because relatively few AFDC-eligible people need LTC services, however, Medicaid spends relatively little on LTC services for people who qualify in this way.

Second, in many states, people who initially do not satisfy these standards may alternatively qualify as "medically needy" after they have "spent down" their assets and incomes--that is, when LTC or other medical purchases have reduced their assets below the state's

TABLE 2. ESTIMATED TOTAL SPENDING ON LONG-TERM CARE SERVICES FOR ALL AGE GROUPS IN FISCAL YEAR 1988, BY TYPE OF SERVICE AND PAYMENT SOURCE

Payment Source	Nursing Home Care[a]	Home- and Community-Based Care[b]	Total
	Billions of Dollars		
Total	44.3	13.6	57.8
Federal	13.3	5.0	18.3
Medicare	0.9	2.4	3.3
Medicaid	11.5	1.3	12.9
VA and other[c]	0.9	1.2	2.2
State and Local	9.5	2.6	12.1
Medicaid	9.4	1.1	10.5
Other[d]	e	1.5	1.6
Private	21.5	6.0	27.5
Out of pocket	20.2	5.1	25.3
Health insurance	f	0.2	0.2
Other[g]	1.3	0.7	1.9

(Continued)

SOURCE: Congressional Budget Office calculations based on estimates compiled by Actuarial Research Corporation.

NOTE: VA = Department of Veterans Affairs.

a. Nursing home care includes services provided in skilled nursing facilities, intermediate care facilities, combinations of skilled and intermediate nursing facilities, intermediate care facilities for mentally retarded people, and noncertified facilities providing some nursing care.

b. Home- and community-based care includes nursing care, speech therapy, physical therapy, occupational therapy, services provided by home health aides and homemakers, medical social services, home-delivered and center-based meals, adult day care, senior centers, and transportation services.

asset threshold and when their income net of medical and LTC expenditures is below the state's income threshold.

Third, some states use a special income level to determine Medicaid eligibility for nursing home residents. This income level is higher than the income eligibility limit for the state's cash welfare assistance programs but cannot exceed three times the maximum SSI benefit

TABLE 2. Continued

Payment Source	Nursing Home Care[a]	Home- and Community-Based Care[b]	Total
As a Percentage of All Spending on Care of That Type			
Total	100.0	100.0	100.0
Federal	30.1	36.6	31.7
Medicare	2.0	17.5	5.6
Medicaid	26.0	9.9	22.2
VA and other[c]	2.1	9.2	3.8
State and Local	21.4	19.2	20.9
Medicaid	21.3	8.1	18.2
Other[d]	0.1	11.1	2.7
Private	48.5	44.1	47.5
Out of pocket	45.6	37.6	43.7
Health insurance	f	1.7	0.4
Other[g]	2.9	4.9	3.3

c. Federal payments for home- and community-based care services are also provided under the Older Americans Act and the Social Services Block Grant.

d. Other state funding includes Medicaid-related payments for which there was no federal matching and funding from state general revenues.

e. Less than $50 million.

f. Not separately identified. Included with "other private."

g. Other private sources of payment include private organizations and, for nursing home care, private insurance.

level for an individual. States without programs for medically needy people use this special income level to provide coverage for their nursing home populations but, in doing so, place an absolute income ceiling on eligibility for Medicaid.[20] In these states, it is possible for individuals to incur nursing home costs that exceed their incomes but to be ineligible for Medicaid because their incomes exceed the special income level.

Eligibility for Medicaid-financed nursing home care is also affected by an individual's marital status. Since September 30, 1989, to prevent Medicaid's "spend-down" provisions from impoverishing nursing home residents' spouses who live in the community, provisions of the Medicare Catastrophic Coverage Act of 1988 that remain in effect have required states to provide a specified level of asset and income protection for spouses when determining the amounts that residents must contribute to the cost of care. Medicaid must attribute half the value of the couple's total resources to each spouse, subject in 1989 to a minimum of $12,000 (or more, at state option) and a maximum of $60,000 for the community spouse.[21] Beginning in 1990, both amounts are to be adjusted for changes in the consumer price index. States must also allow the community spouse to receive enough of the income of the nursing home resident to bring the community spouse's income up to a specified percentage of the federal poverty line for a couple--currently 122 percent ($10,834 per year in January 1991) but scheduled to rise to 133 percent as of July 1, 1991, and to 150 percent as of July 1, 1992.

Evidence on Spending Down of Assets. Contrary to widespread belief, only a small proportion of those admitted to nursing homes spend down their assets after being admitted and thereby become eligible for Medicaid during their stays. Medicaid pays for the care of a considerably larger proportion throughout their stays, however. Overall, 7 percent of all those discharged from nursing homes in 1985 entered with a source of payment other than Medicaid but became eligible for Medicaid during their stays. For another one-third, however, care was financed by Medicaid throughout.[22] Of those discharged from nursing homes in 1985 who had entered as privately paying residents, only about 10 percent spent down their assets during a single episode of nursing home care.

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[20] Some states permit Medicaid eligibility to be established using either the medically needy standard or the special income limit standard because, for people who are dually eligible, the latter standard is administratively simpler.

[21] The results of a survey of the states conducted by the American Association of Retired Persons imply that by March 1990, 17 states with 40 percent of all Medicaid-certified nursing home beds had raised to at least $60,000 the minimum share of a couple's joint assets that the community spouse must be permitted to retain.

Whether nursing home residents spend down their assets, and how quickly they do so, vary considerably.[23] Long stays, however, increase their likelihood of doing so.[24] Among those discharged in 1985 after stays of at least six months, 12 percent spent down to Medicaid eligibility, 48 percent were eligible for Medicaid throughout their stays, and 40 percent paid for their entire stays from sources other than Medicaid; a small proportion of those eligible for Medicaid throughout their stays might have spent down to Medicaid eligibility during previous nursing home stays.[25] Overall, more people spend down in the community than in nursing homes, in part because more of the aged population with disabilities live in the community than in nursing homes. Spend-down in the community appears to be related less to community-based LTC costs than to other medical care costs, however.[26]

Role of Medicaid. How important is Medicaid to the overall financing of formal LTC services? Conversely, how large a role does LTC financing play within the Medicaid program?

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[22] For about an additional one-third of those discharged, care was financed privately throughout the episode of care. For 14 percent, it was financed by Medicare throughout. See D.A. Spence and J.M. Wiener, "Estimating the Extent of Medicaid Spend-Down in Nursing Homes," *Journal of Health Politics, Policy and Law*, vol. 15, no. 3 (Fall 1990), pp. 607-626.

[23] Many people with stays of six months or less spent down and 38 percent of those spending down were discharged within six months. Conversely, 37 percent of those with stays of at least two years did not have Medicaid as a payment source. See K. Liu, P. Doty, and K. Manton, "Medicaid Spenddown in Nursing Homes," *The Gerontologist*, vol. 30, no. 1 (February 1990), pp. 7-15.

[24] Connecticut data suggest that those spending down had the longest average lengths of stay (52 months) and those with care financed throughout from non-Medicaid sources had the shortest average lengths of stay (13 months). See L. Gruenberg and others, "An Analysis of the Spend-Down Patterns of Individuals Admitted to Nursing Homes in the State of Connecticut" (Connecticut Partnership for Long Term Care Research Institute Discussion Paper No. 1-89, September 1989).

[25] Congressional Budget Office calculations based on data in Liu, Doty, and Manton, "Medicaid Spenddown in Nursing Homes," Table 1.

[26] See Liu, Doty, and Manton, "Medicaid Spenddown in Nursing Homes."

Overall, Medicaid funded 47 percent of all nursing home care in fiscal year 1988 and provided 92 percent of public funding for nursing home care, but only 18 percent of total funding for H&CB care (see Table 2).

In 1989, LTC services accounted for 45 percent of all Medicaid spending (see Table 3). Almost two-thirds of this LTC spending was for

TABLE 3. DISTRIBUTION AND AVERAGE COMPOUND GROWTH RATES OF REAL MEDICAID SPENDING, BY TYPE OF SERVICE, FISCAL YEARS 1975 TO 1989 (In percent)

Type of Service	Percentage of 1989 Spending	Average Annual Growth Rate 1975-1989	Average Annual Growth Rate 1975-1981	Average Annual Growth Rate 1981-1989
All Medicaid Services				
Total	100.0	5.2	6.0	4.7
All long-term care services	45.4	6.4	8.1	5.1
All other services	54.6	4.4	4.5	4.3
All Long-Term Care Services				
Nursing Home Facilities Other Than for Mentally Retarded People	28.5	3.7	4.0	3.4
Intermediate Care Facilities for Mentally Retarded People	12.2	15.9	29.8	6.0
Home Health Care	4.7	22.1	24.6	20.1
All Nursing Home Care Other Than for Mentally Retarded People				
Skilled Nursing Facilities	12.2	1.7	1.1	2.2
Intermediate Care Facilities	16.3	5.7	7.2	4.5

SOURCE: Congressional Budget Office calculations based on the Health Care Financing Administration's Medicaid 2082 data.

NOTE: Real spending was calculated using the fixed-weighted deflator for gross national product.

nursing home care either in skilled nursing facilities (SNFs) or in intermediate care facilities (ICFs) for the general population, and another quarter went for nursing home care in ICFs for mentally retarded people (ICF-MRs). Only about one-tenth of Medicaid LTC spending was for home health services.

Growth in Medicaid LTC Spending in Constant Dollars. After adjustment for inflation, the average annual growth rate in Medicaid spending on LTC from fiscal years 1975 to 1989 was 6.4 percent, slightly higher than the 5.2 percent rate for Medicaid spending overall (see Table 3). Medicaid spending--both in total and on LTC services--grew faster from 1975 to 1981 than it did from 1981 to 1989. Medicaid spending on different kinds of LTC services, however, grew at quite different average annual rates over the period from 1975 to 1989--4 percent for nursing home care in SNFs and ICFs considered together, 16 percent for nursing home care in ICF-MRs, and 22 percent for home health care services. Growth in the ICF-MR program was particularly rapid during the period from 1975 to 1981, averaging 30 percent per year compared with 6 percent from 1981 to 1989. Growth in ICF-MR and home health care spending was calculated from low base levels, however, and in 1989 these two components still accounted for little more than one-third of Medicaid's LTC spending.

Growth in total Medicaid spending during the 1975-1988 period, after adjustment for inflation, was attributable primarily to increased real spending per Medicaid recipient, because the total number of recipients grew quite slowly (0.3 percent per year--see Table 4). Annual growth in real spending, which averaged 6.0 percent between 1975 and 1981, fell to 4.4 percent between 1981 and 1988.

Medicaid spending on all nursing home services, after adjustment for inflation, grew at an average annual rate of 5.8 percent between 1975 and 1988. Annual real growth slowed from 7.7 percent between 1975 and 1981 to 4.1 percent between 1981 and 1988. Increases in real spending per recipient contributed more than increases in the number of recipients to the growth in real Medicaid spending for nursing home

TABLE 4. SOURCES OF GROWTH IN REAL MEDICAID SPENDING, BY TYPE OF SERVICE, FISCAL YEARS 1975 TO 1988
(In percent per year)

Type of Service and Source of Growth	Average Annual Growth Rate 1975-1988	1975-1981	1981-1988
All Medicaid Services			
Total spending	5.1	6.0	4.4
Spending per recipient	4.8	6.0	3.8
Number of recipients	0.3	0.0	0.6
All Medicaid Nursing Home Services			
Total spending	5.8	7.7	4.1
Spending per day of care	0.9	0.8	0.9
Total days of care	4.9	6.8	3.1
Skilled Nursing Facilities			
Total spending	1.8	1.1	2.5
Spending per day of care	-1.4	-4.0	1.0
Days of care per recipient	3.9	5.9	2.2
Number of recipients	-0.6	-0.5	-0.7
Total days of care	3.3	5.3	1.5
Intermediate Care Facilities			
Total spending	5.6	7.2	4.1
Spending per day of care	0.8	1.2	0.4
Days of care per recipient	2.9	4.1	1.8
Number of recipients	1.8	1.8	1.8
Total days of care	4.7	6.0	3.7
Intermediate Care Facilities for Mentally Retarded People			
Total spending	16.7	29.8	6.1
Spending per day of care	3.1	5.7	0.8
Days of care per recipient	7.0	8.3	5.9
Number of recipients	5.8	13.3	-0.6
Total days of care	13.2	22.8	5.3
Home Health Care			
Total spending	22.1	24.6	19.8
Spending per recipient	17.5	21.5	14.0
Number of recipients	3.9	2.6	5.1

SOURCE: Congressional Budget Office calculations based on the Health Care Financing Administration's Medicaid 2082 data.

NOTE: Real spending was calculated using the fixed-weighted deflator for gross national product.

care in each of SNFs, ICFs, and ICF-MRs.[27] ("Recipient," here and in the discussion below, means a person receiving care of the relevant kind.)

A complementary perspective on the sources of growth in Medicaid's real spending on nursing homes focuses on two related questions.

- Has the number of days of care for which Medicaid pays grown faster than Medicaid's real spending per day of care?

- If so, has Medicaid been paying for more days of care primarily because it was paying for a growing average number of days per recipient or because it was assisting a growing number of recipients?

Data on the number of days of care for which Medicaid pays may be less reliable than those for Medicaid spending and for the number of recipients. So estimates of trends in real spending per day of care and in days of care per recipient may be less accurate than the estimates discussed above. With that important proviso, the reported data suggest two important patterns.

First, most growth in real spending on nursing home care reflected growth in the number of days of care for which Medicaid paid rather than growth in real spending per day of care.

- Between 1975 and 1988, the number of days of care for which Medicaid paid grew 4.9 percent per year, considerably faster than real Medicaid spending per Medicaid-financed day of care.

- Between 1975 and 1988, real Medicaid spending per Medicaid-financed day of care grew by only 0.9 percent per year when averaged across all nursing homes, although the rate was somewhat higher for ICF-MRs (3.1 percent) than for SNFs (-1.4 percent) and ICFs (0.8 percent).

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27. This finding is not shown directly in Table 4 but is implied. The growth rate of real spending per recipient is approximately equal to the sum of the growth rates of real spending per day of care and of days of care per recipient.

Second, growth in the number of days for which Medicaid paid resulted more from growth in the number of days of care per recipient than from growth in the number of recipients.

- In general, the number of Medicaid-financed days of care per recipient--whether for SNFs, ICFs, or ICF-MRs--grew more rapidly than the number of recipients of care. The main exception was for ICF-MRs between 1975 and 1981, when annual growth in the number of recipients averaged 13.3 percent compared with 8.3 percent for days of care per recipient.

- It would be interesting to know whether growth in the number of Medicaid-financed days of care per recipient was due mainly to lengthening stays for Medicaid-eligible nursing home residents or, alternatively, to Medicaid's assumption of financial responsibility for their care earlier in their stays. Data to resolve this question, however, are unavailable.

Medicaid spending on home health care services, after adjustment for inflation, grew at an average annual rate of 22.1 percent between 1975 and 1988 (see Table 4). This reflected average annual growth of 17.5 percent in real spending per recipient and of 3.9 percent in the number of recipients. Patterns of growth changed, however, between the subperiods 1975 to 1981 and 1981 to 1988. Between these subperiods, average annual growth fell for real spending (from 24.6 percent to 19.8 percent) and for real spending per recipient (from 21.5 percent to 14.0 percent), but it rose for the number of recipients (from 2.6 percent to 5.1 percent).

Medicare

Medicare is a social insurance program that finances acute health care for eligible people who are aged or who have disabilities. Accordingly, it funds skilled and rehabilitative services that are required for short periods as part of acute health care episodes and that are provided in a nursing facility or in a person's own home. Medicare funds care in a nursing facility, however, only if it follows a period of hospitalization--a restriction that does not apply to home health care services. The services funded (for example, physical therapy to reestablish strength and flexibility after a fractured hip is surgically repaired) may be substantially the same as those required by people who need LTC because of chronic conditions or functional limitations (for example, ongoing physical therapy to maintain strength and flexibility after a stroke). Medicare, however, does not fund services that are solely for chronic conditions.

Medicare also funds supportive services (such as assistance by a home health aide) if the need for these services results from a covered episode of acute care. Once again, the services funded are similar to those required by people with chronic conditions or functional limitations, but Medicare does not fund services solely for chronic conditions.

Thus, part--and perhaps most--of Medicare funding for nursing home and home health services might better be thought of as expenditures on acute health care than as expenditures on LTC, although the relevant proportion is hard to estimate from available data. Consequently, such Medicare expenditures can be treated in different ways when estimating total spending on LTC. Consistent with other recent discussions of LTC expenditures, Table 2 includes them all. Nevertheless, there are significant limitations on the range of conditions for which Medicare will fund these services. Most notably, conditions of a chronic nature, which are the traditional focus of LTC services, are excluded.

On this basis, Medicare funded 5.6 percent of all LTC expenditures in fiscal year 1988, paying for 32 percent of publicly funded home health care but for only 4 percent of publicly funded nursing home care (see Table 2). Medicare home health expenditures grew at an average annual rate of 9.9 percent during the 1982-1988 period. This reflected average annual rates of increase of 5.3 percent in the number of people served--that is, the number receiving visits--and of 4.3 percent in the average reimbursement per person served. Over the same period, however, the number of home health visits per person served fell from 26 to 24.[28]

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28. Congressional Budget Office calculations based on home health agency data provided by the Department of Health and Human Services.

The Medicare Catastrophic Coverage Act (MCCA) of 1988 expanded Medicare coverage of care provided in skilled nursing facilities (SNFs) beginning January 1, 1989, but the changes were phased out beginning January 1, 1990, following repeal of the MCCA. During 1989, however, Medicare's coverage of SNF care:

- Was no longer limited to people who had stayed three days in an acute hospital before their admission to the SNF;
- Was extended from a maximum of 100 days per spell of illness to a maximum of 150 days per calendar year;[29] and
- Became subject to a new copayment structure that substituted relatively low copayments during the first eight days of each calendar year for relatively high copayments beginning on day 21 of each spell of illness.

These changes were superimposed on new administrative guidelines adopted in April 1988 to clarify eligibility for the Medicare SNF benefit. The new guidelines changed the focus from the type of care not covered to the type of care covered. Separately, a U.S. District Court ruling applying within Connecticut required the Medicare program to use new and less restrictive criteria starting in April 1988 when deciding whether people who require physical therapy are eligible for Medicare-financed SNF care.[30] Both sets of administrative changes appear to have broadened the range of circumstances in which people would be deemed eligible for Medicare-financed SNF care, thereby increasing the number of people covered and possibly the average duration of their covered care. Reflecting all of these changes, annual expenditure growth in the Medicare SNF benefit was 16 percent in fiscal year 1988, 205 percent in 1989, and 14 percent in 1990.

The MCCA also changed Medicare's definition of "intermittent" home health care, expanding the maximum permitted coverage from five days per week during a 21-day period to seven days per week during a 38-day period. This change was also repealed.

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[29] A spell of illness begins with a hospital admission and ends 60 days after discharge from the hospital or from a skilled nursing facility entered immediately subsequent to the hospital stay.

[30] *Fox* v. *Bowen*, 656 F. Supp. 1236 (D. Conn. 1987).

Department of Veterans Affairs

The Department of Veterans Affairs (VA) provides LTC services to veterans who have service-connected disabilities or have limited resources. It assists other veterans to the extent that funds permit. The VA and other federal sources together funded an estimated 4 percent of all LTC expenditures in fiscal year 1988.

CHAPTER II

PROSPECTS FOR THE LONG-TERM CARE SYSTEM UNDER CURRENT LAW

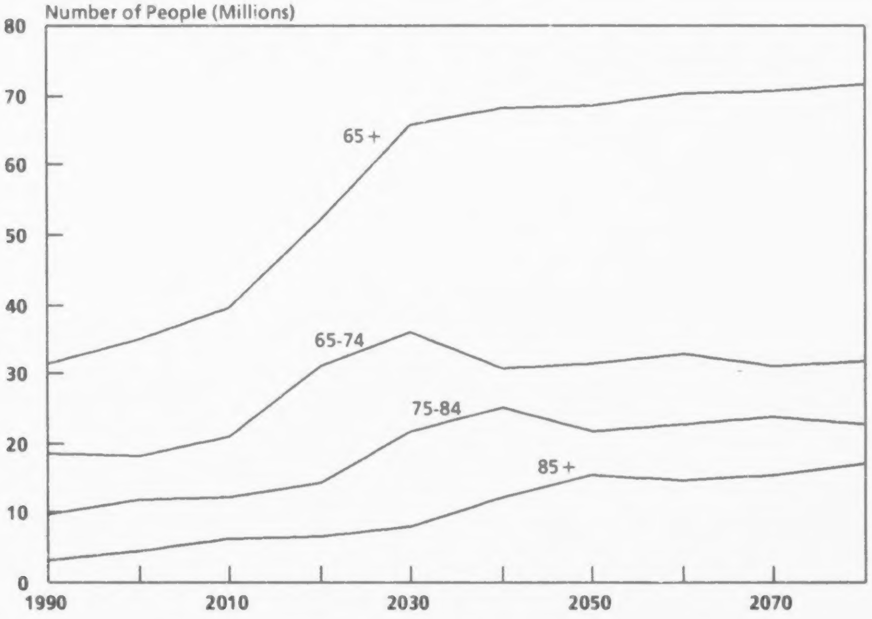
When contemplating changes in policy, one obvious question to ask is what would happen if current law and policy were to remain unchanged. This chapter addresses that question by exploring the concerns of both fiscal and performance critics of the present system. Accordingly, the chapter examines how the demand for and cost of LTC services might grow in coming decades under current law as well as the prospects for containing future federal costs. It also considers prospects for financial access to LTC services and related concerns.

PROJECTED TOTAL COSTS FOR LONG-TERM CARE

Spending for LTC is expected to increase significantly in coming decades. Demographic factors will determine the growth of the population at risk for LTC, while morbidity and functional disability rates will affect the share of that population needing services. Spending will also depend on how quickly the prices of services rise (they have risen faster than general inflation for the last two decades) and on the "intensity" of care (that is, real goods and services provided per unit of service), which has also been growing. Because most of these factors are subject to considerable uncertainty, particularly over the long run, projections of spending vary substantially.

Demographic trends toward an older population with substantially more people in the oldest age groups can be expected to increase dramatically the demand for LTC. Figure 1 shows projected demographic shifts between 1990 and 2080 in the size and age structure of the population aged 65 or older. Two factors are fundamental to these shifts. First, the "baby boom" begins to reach age 65 after 2010, age 75 after 2020, and age 85 after 2030. In addition, mortality rates are projected to decline. Thus, the size of the population aged 65 or older is expected to surge upward until 2030, rising by 25 percent over 1990 levels by 2010 and more than doubling by 2030. (To place this in perspective, the total population is projected to increase by 20 percent between 1990 and 2030.) Even more important, as mortality declines, the aged population will become more concentrated in the oldest age group--those aged 85 or older. The projected size of this cohort grows dramatically from its 1990 level--up 88 percent by 2010, 150 percent by 2030, and 370 percent by 2050. Thus, the oldest cohort will account for 12 percent of the population aged 65 or older in 2030 and 22 percent in 2050, compared with only 10 percent in 1990. As a proportion of the total population, it will account for 2.7 percent in 2030 and 5.1 percent in 2050, compared with 1.3 percent in 1990. So the relative size and age structure of the aged population are not projected to stabilize until the second half of the next century.

Figure 1.
Projected Growth of U.S. Population Aged 65 or Older, by Age Group and Year

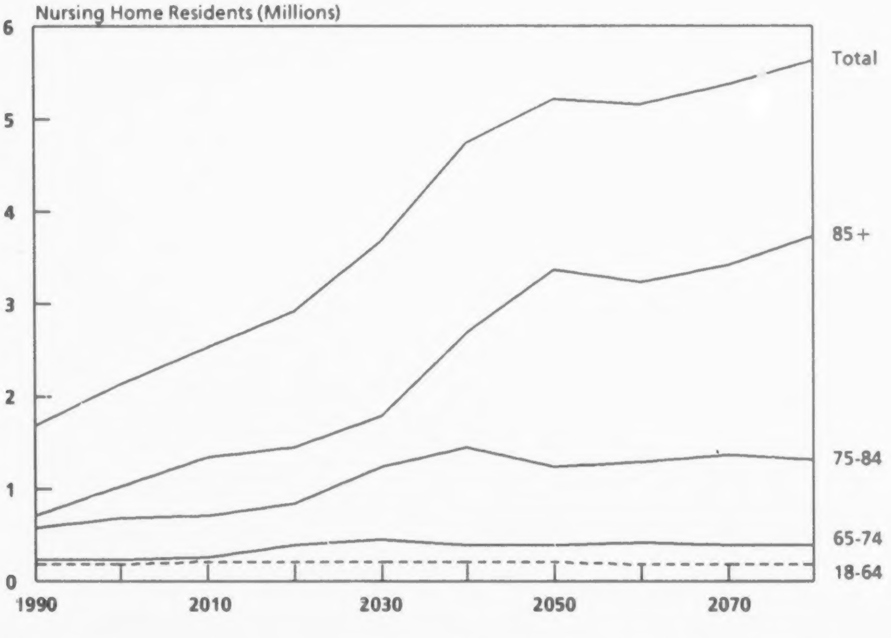


SOURCE: Bureau of the Census, Current Population Reports, series P-25, no. 1018 (January 1989), Table 4.

The increasing concentration in the oldest age category has important implications for the use of LTC, because LTC use rises sharply with advancing age. If the rates of nursing home use by age category remain the same, about 2.5 million aged people in the year 2010, 3.7 million in 2030, and 5.2 million in 2050 will reside in nursing homes, compared with 1.7 million in 1990 (see Figure 2). In other words, the nursing home population would increase to 1.5 times its 1990 level by 2010, would double it by 2030, and would treble it by 2050.

The growth in total spending on LTC could be dramatic. The specific numbers in such projections are uncertain because, as noted

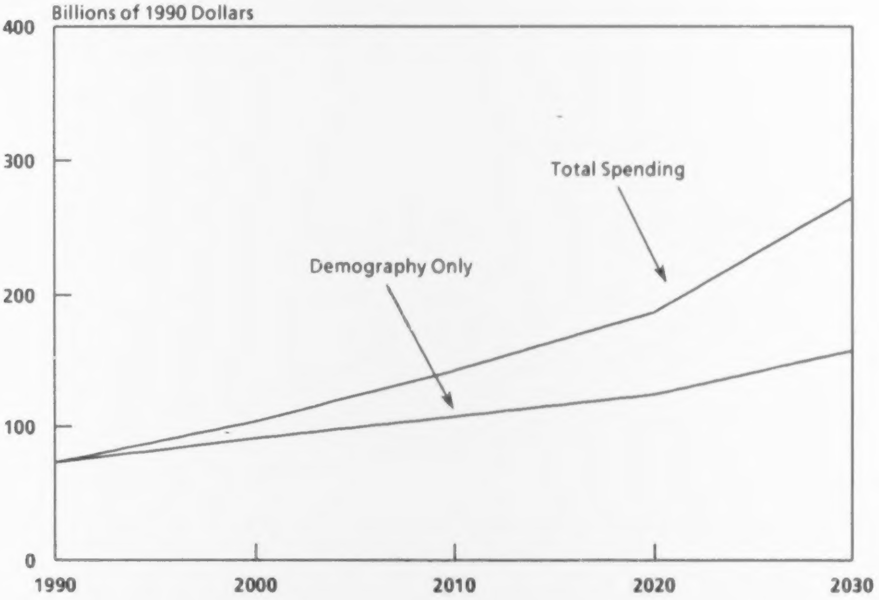
Figure 2.
Projected Number of Nursing Home Residents, by Age of Resident and Year



SOURCE: Congressional Budget Office calculations based on Bureau of the Census, Current Population Reports, series P-25, no. 1018 (January 1989), Table 4, and 1985 age-specific rates of nursing home use.

earlier, demographic factors, medical care prices, and intensity of services will all influence LTC spending. Figure 3 shows the growth in expenditures for the 1990-2030 period that would be implied by the demographic trends noted above if, as well, the excess of annual growth in LTC prices over general inflation matched that of Medicaid

Figure 3.
Projected Long-Term Care Spending in 1990 Dollars
Under Illustrative Assumptions



SOURCE: Congressional Budget Office calculations based on Bureau of the Census, Current Population Reports, series P-25, no. 1018 (January 1989), Table 4; Bureau of the Census, Current Population Reports, series P-25, no. 1022 (March 1988), Table 1; and 1985 age-specific rates of nursing home use.

NOTE: Projected total spending assumes the demographic changes reflected in Figures 1 and 2, growth in long-term care prices that exceeds general inflation by 0.94 percent per year, and growth in the "intensity" of care--real goods and services provided per unit of service--of 0.44 percent per year.

Projected spending under the "demography only" assumption assumes, in contrast, that growth in long-term care prices will be the same as general inflation and that there will be no growth in the intensity of care.

expenditures per day of care during the 1981-1988 period (0.94 percent per year), and if growth in service intensity were 0.44 percent per year. (This is the rate of Medicaid's real spending growth on nursing home care between 1981 and 1988 that is not attributable to demographic changes or to excess inflation in prices of nursing home care.) Under these assumptions, total LTC spending in constant dollars would be almost twice its 1990 level in 2010. Figure 3 also shows the growth in expenditures that would result from demographic trends alone. Clearly, the projected increases in LTC prices and in service intensity also contribute substantially to the projected growth in total LTC spending.

Of course, many other factors could also affect growth in LTC spending. For example, improvements in medical knowledge and technology could substantially lower expenditures for LTC by reducing morbidity or, alternatively, could substantially raise these expenditures by extending life expectancy without commensurate reductions in morbidity. Improving economic status among older people or increasing private LTC insurance coverage of the population might expand LTC demand, raising spending. If asset accumulation were not to keep pace with the growth in LTC costs (for example, if housing prices should grow more slowly), then demand and spending might decrease. In addition, any trend toward smaller family sizes or higher rates of divorce could reduce the number of people likely to be available as informal caregivers for frail aged people. Moreover, if the proportion of women in the labor force continues to rise, the proportion who are willing to forgo potential earnings to provide informal care might decrease. The latter trend could also increase the demand for, and the use of, formal LTC services, just as it has substantially increased the use of paid child care services.

PROSPECTS FOR CONTAINING FUTURE FEDERAL COSTS

Given this projected magnitude of LTC expenditures, federal outlays in this area will increase significantly. It is thus natural to examine the strategies currently used to contain federal outlays and to seek additional cost-containment strategies that might reduce this implied growth in federal LTC outlays. Some approaches that would contain federal costs could increase LTC costs for other payers.

The potential for policy changes that would avoid the increases in LTC outlays projected under current law appears to be limited. One of Medicaid's most effective mechanisms for controlling costs is the requirement that individuals exhaust their own resources before becoming eligible for publicly subsidized LTC services. Accordingly, rather than containing costs, proposals to expand access to LTC and reduce its financial burden on individuals would likely require resources beyond those needed to meet commitments under current law.

Current Strategy for Containing Federal LTC Costs

A number of methods are used to limit federal outlays for LTC in both the Medicaid and the Medicare programs. Under Medicaid, four principal mechanisms are used:

- The means-tested nature of the Medicaid program, which significantly limits the number of people eligible for Medicaid-financed services;
- Limitations on Medicaid coverage of home- and community-based care, even for those who are eligible for Medicaid;
- The significant degree of federal/state sharing of costs that Medicaid imposes on the states, which gives states strong incentives to develop effective cost-containment programs and to keep Medicaid efficient; and
- Control by the states over growth in Medicaid rates of reimbursement to providers.

Within Medicare, LTC outlays have been limited mainly through provisions restricting the scope of covered LTC services or the circumstances in which they are covered.

Although spend-down and coverage exclusions are the centerpieces of federal cost-containment policy, much of the public debate and hence much of this study concern policies such as expanding private or public arrangements for pooling risks that would implicitly reject these strategies. A primary obstacle to adopting such policy changes is the effect they would have on federal LTC costs. Thus, identifying effective approaches to containing LTC costs is of interest whether or not current law remains in force.

Possible Approaches to Cost Containment

Five possible approaches to containing federal LTC costs are discussed below: cost sharing, systems for reimbursing providers, managed care and case management, regulation of supply, and changes in program scope. To help contain federal costs under LTC programs, these mechanisms would need to affect one or more of the following factors:

- The proportion of the total population covered by the programs;
- The participation rate among those covered;
- The mix of services between high-cost and low-cost services;
- The average number of units of each service per participant;
- The average unit price of government-subsidized services; and
- The proportion of this price paid by the federal government.

The health policy literature contains many discussions of mechanisms for cost containment. Nevertheless, apart from evaluations of various H&CB care demonstration programs, little research has been done on how effectively these mechanisms actually control costs, either per unit of service or overall. Moreover, the evidence available on cost containment relates much more to acute health care services than to LTC services. Despite this lack of viable information, there is little basis for optimism that the projected costs of LTC could be lowered significantly other than by restricting the scope of current programs.

Individual Cost Sharing. Cost sharing consists of out-of-pocket payments for services. It may involve an initial deductible amount that is not covered and proportional coinsurance for costs above the deductible amount. Deductible and coinsurance amounts can be made subject to ceilings that may be related to a person's resources. By making the user pay part of the costs of care, cost sharing provides a disincentive to consumer demand, particularly if the copayments are not covered by supplementary insurance. The drawbacks of cost sharing are that it tends to discourage all use--not just excessive use--and that cost-sharing payments of any given size have the greatest effect on those with the least resources.

Medicaid embodies a stringent form of cost sharing, for it requires LTC beneficiaries to spend all but defined amounts of their own income and assets on their LTC costs. The deductible within this cost-sharing regimen is therefore all income and financial assets that are not exempt for the purposes of spend-down. This approach keeps costs down by severely limiting the number of people eligible for publicly subsidized services to those who, without public assistance, have insufficient income and assets to cover the cost of care.

Systems for Reimbursing Providers. Systems for reimbursing providers affect government expenditures for services directly by establishing the price that will be paid under public programs and indirectly by affecting the willingness of nursing homes to accept Medicaid or Medicare patients. They also create the incentive structure to which providers respond and have therefore been used in attempts to create incentives for efficient care--for example, through prospective case-mix reimbursement and capitation reimbursement.[1]

Under prospective reimbursement, the payment rate for a unit of care is based on expected or "legitimate" costs for the average case, rather than the actual costs incurred for a particular person. Thus, at the end of the period, there is no reconciliation of the amount reimbursed with actual costs incurred. Prospective reimbursement can be either facility-related, if it takes into account the particular characteristics of a facility (such as its size, location, type of ownership, or historical costs relative to those of other facilities), or facility-independent, if it disregards them. Evidence suggests that prospective reimbursement, particularly if it is facility-independent, may help to reduce the growth in costs but that it results in reduced staffing levels within nursing homes and creates incentives for nursing homes to admit residents who need light care--care requiring relatively few nursing hours--rather than heavy care.[2]

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[1] A third approach would involve "outcome-related" reimbursement--see, for example, R.L. Kane and others, *Outcome-Based Reimbursement for Nursing-Home Care* (Santa Monica: RAND Corporation, December 1983). This approach, however, has not been used in any systematic way within Medicaid.

Currently under Medicaid, several states distinguish categories of costs (for example, administration, nursing, and food) and reimburse each category separately subject to separate caps. Some people are concerned that any staffing reductions associated with prospective reimbursement would reduce the quality of care rather than increase its efficiency. If these concerns could not be addressed adequately through quality assurance mechanisms, modifying prospective reimbursement to differentiate between direct care costs and other costs in this way might help to discourage such staffing effects.

Forms of prospective reimbursement that incorporate case-mix adjustments might help to avoid incentives for providers to choose residents who require light rather than heavy care. Case-mix reimbursement defines distinct categories of care recipients for which expected costs of care differ and for which different payment rates are set.[3] Prospective case-mix reimbursement rewards efficiency. In fiscal year 1987, only four states reimbursed both skilled nursing and intermediate care facilities under Medicaid on a retrospective, reasonable-cost basis. The rest had adopted prospective payment systems for SNF services, ICF services, or both. Seven states incorporated case-mix adjustments within their reimbursement systems, and others were experimenting with them.

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[2] J. Holahan and J. Cohen, "Nursing Home Reimbursement: Implications for Cost Containment, Access, and Quality," *The Milbank Quarterly*, vol. 65, no. 1 (1987), pp. 112-147. Also, J.W. Cohen and L.C. Dubay, "The Effects of Medicaid Reimbursement Method and Ownership on Nursing Home Costs, Case Mix, and Staffing," *Inquiry*, vol. 27 (Summer 1990), pp. 183-200.

[3] New York State's Resource Utilization Groups (RUGs II) system illustrates prospective case-mix reimbursement. It classifies nursing home residents into 16 groups that were selected because they were considered to involve similar levels of resource use, to be clinically valid groupings, and to identify, for higher reimbursement, those residents receiving rehabilitative services. A separate reimbursement rate applies to residents in each RUGs II group.

More recently, in the wake of the rapid growth of enrollment in health maintenance organizations (HMOs, discussed below), the potential of prepaid capitation payment systems to control LTC costs has been considered. Under capitation reimbursement, providers agree to supply all of the care within a contractually defined range that an individual needs in exchange for a fixed payment per person--equivalent to an insurance premium. In effect, capitation reimbursement treats nursing home care as part of a broader bundle of services, such as all LTC services, or all acute and LTC services. This system rewards efficient choices among preventive, acute, and long-term care.

Two programs are testing the effects of capitation reimbursement for services that include LTC. Both involve experimental LTC delivery systems. One is the Social Health Maintenance Organization demonstration and the other is On Lok Senior Health Services.

The Social Health Maintenance Organization (SHMO) demonstration, which is operating in four sites, extends the HMO concept and serves Medicare enrollees whose health status reflects the mix in the aged population overall. The SHMO adds both nursing home care and H&CB services to the range of acute health care services that an HMO is contractually obligated to provide. In the SHMO system, LTC use is subject to annual cost limits per member, which varied across sites from $6,500 to $12,000 per year in 1988. The SHMOs target their LTC services toward individuals who are medically eligible for nursing home care, and they receive a higher capitation rate than HMOs to cover the expected cost of providing these additional services. The SHMOs avoid the problem of adverse selection (that is, enrolling a disproportionate number of applicants whose risk of needing LTC services is high) by establishing a waiting list for people at high risk and limiting their rate of enrollment so that the proportion of SHMO enrollees in this category rises no higher than their proportion of the overall aged population.

Final results are not yet available from the evaluation of the SHMO demonstrations. It is not clear whether the SHMO approach could be generalized to a much larger population, even if it is found to be effective in controlling costs. The SHMOs proved easier to establish when a viable HMO was already functioning than when systems for developing both acute care and LTC had to be developed concurrently.[4]

On Lok Senior Health Services goes beyond the SHMO demonstration by covering nursing home care regardless of its duration and by enrolling only people who, under the California Medicaid program, meet eligibility standards for admission to a nursing home. The On Lok program uses the day health center as its primary setting for delivering services and accepts full financial responsibility for providing complete medical, hospital, and social services to all of its highly dependent, predominantly Chinese-American clients. On Lok receives capitated funding from Medicare and Medicaid for eligible clients, which averages about $2,650 per client per month in 1991. All On Lok clients covered by capitated funding arrangements receive LTC services. In most other examples of capitated funding, only a proportion of the covered population actually receives services.

The On Lok program has not been formally evaluated by independent investigators, although On Lok staff claim that the program has reduced the use of hospital and nursing home beds by its nursing-home-eligible population. They found that the reductions in hospital use were associated with shorter stays and with fewer admissions for exacerbation of chronic conditions and diagnostic work.[5] A demonstration is under way to assess how successfully the On Lok model of care can be transferred from an ethnically homogeneous community in a densely populated urban area to other settings and geographic regions.

It is unclear how effectively capitation reimbursement, when combined with case-management and managed-care approaches to allocating services (discussed below), can contain LTC costs. The answer will depend on several factors, including whether programs like the SHMO demonstrations and On Lok prove on further evaluation to offer cost savings compared with conventional delivery systems, whether they are adaptable to a range of different geographic settings, whether people at risk of needing LTC will enroll in such programs in preference to conventional delivery systems, and whether an adequate methodology can be found to determine the capitation rate that would just cover the necessary costs of satisfactory care for efficient providers.

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[4] W. Leutz and others, "Adding Long-Term Care to Medicare: The Social HMO Experience," mimeo (January 1990); forthcoming in *Journal of Aging and Social Policy*.

[5] See R.T. Zawadski and C. Eng, "Case Management in Capitated Long-Term Care," *Health Care Financing Review* (1988 Annual Supplement), pp. 75-81.

Managed Care and Case Management. "Managed care" seeks to structure health care financing and delivery so that only necessary and appropriate care is provided, thereby reducing the costs and enhancing the quality of care. It developed mainly in relation to acute care--primarily through HMOs that contract with individuals or families to provide all needed care within a defined range of services in exchange for a fixed payment. Because HMOs combine the functions of insurance and care provision within a single organization, they have both the incentive and the ability to choose efficiently among preventive and acute care and to contain costs.

The evidence on how HMOs affect acute care costs, which is mixed, offers insight into the possible effects on costs that might result from extending managed care techniques to cover LTC services. Overall, HMOs that are well-integrated financing and delivery systems (in particular, staff-model and some group-model HMOs) appear able to achieve a one-time reduction in hospital use and costs. Such HMOs are not typical, however, and they require greater financial commitment to establish and operate than is true for delivery systems that are less integrated. In addition, even HMOs that succeed in reducing costs have the same annual rates of cost increase as fee-for-service organizations. Moreover, the administrative costs of managed care can be substantial and can outweigh potential savings.[6]

Although the managed care concept typically applies to acute health care, it has analogues within LTC. The SHMO and On Lok experimental delivery systems, for example, are reimbursed under capitation arrangements and therefore must manage care to remain financially viable. Managed LTC of this kind combines assessment and monitoring of LTC needs with direct provision of the services ordered, and is sometimes referred to as the "consolidated model" of case management.[7]

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[6] See Congressional Budget Office, "Managed Care and the Medicare Program: Background and Evidence," CBO Staff Memorandum (May 1990).

The term case management is used more generally in LTC to refer to various combinations of ongoing assessment, prior authorization of services, and care coordination. The consolidated model of case management may be distinguished conceptually from two other, less-intensive models, although in practice case-management systems may involve elements of each model. In the "brokerage model," a health professional independently assesses the client, arranges services through other providers, and regularly reassesses and follows the client. In the "preadmission screening model," the most limited form of case management, a health professional assesses an individual who is considering entering institutional care and either authorizes that care if it is appropriate or refers the person to alternative community services.

Preadmission screening is typically seen as a cost-containment tool. One demonstration program, the South Carolina Community Long-Term Care Project, was found to decrease the use of nursing home services without increasing public costs for a client sample having both impairment and a high likelihood of nursing home placement.[8] That program combined preadmission screening with relatively inexpensive case management and the expanded provision of services under Medicaid waivers (exemptions from normal Medicaid rules, which are discussed further in Chapter IV). Other attempts to demonstrate that preadmission screening effectively contains costs have failed, however.

The brokerage model is commonly viewed as a way to promote the client's best interests, but it can also help to avoid unnecessary costs for formal care. In some cases, the model avoids unnecessary services altogether; in others, it substitutes informal care, transferring care costs to informal caregivers in monetary or nonmonetary forms. If the brokerage model is used partly to contain costs, the professional who assesses and authorizes services must balance the competing interests of clients seeking potentially beneficial services and of funding sources seeking to avoid unnecessary costs. The effectiveness of this model in containing costs would therefore depend partly on how the professionals involved--nurses, social workers, therapists, and doctors--balanced their conflicting roles as advocates for their clients and gatekeepers restricting access to services for economic reasons. Its effectiveness would also depend on the broader context in which the model was applied.

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[7] See Zawadski and Eng, "Case Management."

[8] See Department of Health and Human Services, *Evaluation of Community-Oriented Long-Term Care Demonstration Projects*, Health Care Financing Extramural Report, HCFA Pub. No. 03242 (May 1987).

The brokerage model, in combination with expanded public financing for H&CB care, has been shown to increase total LTC costs. A primary source of the evidence for this comes from the largest of the community care demonstration programs, known as Channeling, which is discussed in more detail later in this section. Nevertheless, decisions are sometimes made to expand H&CB programs for reasons other than cost--for example, because the resulting mix of services is seen as more appropriate or as promoting improved quality of life for those needing care and for their informal caregivers. In such cases, it would be wrong to conclude from the available evidence that case-management agencies should not administer a home care program.

For example, case-management agencies using a form of the brokerage model have been shown to have certain advantages as administrative systems. Although systematic evidence comparing the effects of various types of administrative systems for H&CB care and LTC is lacking, evidence from Channeling points up the potential benefits of the case-management agency system. The program proved able to substitute lower-cost for higher-cost H&CB services, to negotiate prices below those prevailing in the market, and to create improved incentives for assuring quality through the knowledge of client outcomes that ongoing assessment made available. Achieving these benefits appeared to depend on the agencies' having power to authorize payment for publicly funded services and incentives to limit costs, and on their providing case-management services.[9]

The evidence also points up a disadvantage of a case-management agency system in that Channeling did not succeed in limiting benefits strictly to the eligible population. Yet adhering to eligibility restrictions and limiting the cost per participant are both important if total program costs are to be minimized. Moreover, case-management agency systems entail other costs--the administrative costs of determining eligibility, contracting with providers, and paying bills added roughly 6 percent to 10 percent to the combined cost of case-management services and H&CB services.

What use do state Medicaid programs make of case management? Most states require preadmission screening of Medicaid-financed nursing home residents' conditions to determine whether they meet the program's medical criteria of need for nursing home care. In addition, some states incorporate a brokerage model of case management within their Medicaid system. These include states that provide H&CB services under Medicaid waiver authority--exemptions from normal Medicaid rules that give states greater flexibility--and states that have developed more comprehensive H&CB care systems by integrating different sources of funding.

Regulation of Supply. This approach to cost containment creates regulatory mechanisms that are intended to forestall the provision of unnecessary LTC. Examples include requiring prior certification that new LTC facilities are needed and using bed-to-population ratios to establish limits on the overall number of nursing home beds that would be licensed. Some states have used moratoria on new nursing home beds or certificate-of-need (CON) requirements in attempts to constrain nursing home growth and, thus, the number of Medicaid-eligible individuals in nursing homes.

Some observers consider supply constraints to be among the more effective approaches to cost containment in nursing home care, particularly where bed-to-population ratios are appreciably higher than the national average. Others contend that there is no rigorous evidence demonstrating this to be true and that creating a degree of monopoly power for existing providers could be expected to raise costs per bed. Moreover, reducing the number of Medicaid-eligible nursing home beds would not reduce Medicaid outlays on nursing home care if the beds removed from the overall stock would have been empty or occupied by people ineligible for Medicaid. Furthermore, if the beds removed from this stock would indeed have been used by Medicaid-eligible individuals, these individuals might end up waiting at Medicaid's expense in much more costly hospital beds until a Medicaid nursing home bed became available. A further drawback with supply controls is that objective standards on which to base specific growth control guidelines are lacking. Thus, needed care might be denied because of an inadequate supply.

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[9] P. Kemper, "Case Management Agency Systems of Administering Long-Term Care: Evidence from the Channeling Demonstration," *The Gerontologist*, vol. 30, no. 6 (1990), pp. 817-824.

Reducing the Scope of Programs. This approach could reduce federal costs by reducing the number of people the program covers, the range of services it provides, the units of each service that an eligible person may receive, or the federal share of service costs.

Reductions in program scope are always possible. The real issue, however, is what reductions, if any, would be acceptable. For example, Medicaid's spend-down provisions already limit eligibility for assistance to those meeting stringent asset and income limits, preadmission screening has been used by a majority of states to prevent medically inappropriate admissions to Medicaid-reimbursed nursing home care, and Medicaid expenditure patterns imply that the range of services it finances is in practice limited largely to nursing home care.

One change has often been advocated as a way to reduce the cost of LTC programs without reducing their scope. This change involves modifying the public financing rules that currently encourage the use of expensive nursing home services by providing more generous subsidies of these services than of H&CB services. A number of demonstration programs--of which Channeling was the largest and most rigorous--were instituted during the late 1970s to assess whether offering H&CB services would result in the substitution of lower-cost for higher-cost services. The evaluations of these demonstration programs indicated, however, that offering H&CB services in general does not reduce public costs, although it can enhance the quality of life for individuals and their informal caregivers who would otherwise face financial barriers to obtaining these services.[10]

The primary reason that costs stay the same or rise is that it is difficult to design a program that offers subsidized H&CB services only to those individuals who otherwise would enter a nursing home. In practice, providing H&CB services to people who would not have entered nursing homes typically absorbs at least as many additional resources as the resources "saved" by deferring or avoiding nursing home care for those who would have entered nursing homes. Aside from the South Carolina demonstration program, no screening methodology has been able to identify effectively those individuals who are truly at risk of institutionalization, particularly for long periods of care.

PROSPECTS FOR ACCESS AND RELATED CONCERNS

This section turns from the concern of fiscal critics over the actual and projected costs of the current LTC system to the concern of performance critics over whether people who need LTC have access to an appropriate level and mix of services at reasonable costs. Because terms like "appropriate" and "reasonable" are value laden, it is not surprising that a range of views exists on the severity of problems relating to access. The section examines first the current situation concerning access to LTC services and then considers the nature of concerns over access and the associated financial implications.

Evidence Concerning Access

Given the ongoing concerns expressed about access to LTC, it is perhaps surprising that reliable quantitative evidence from nationwide studies is not available to answer two key questions for LTC policy--whether there is a shortage of services overall, and whether individ-

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10. See "The Evaluation of the National Long Term Care Demonstration," special issue of *Health Services Research*, vol. 23, no. 1 (April 1988); and Department of Health and Human Services, *Evaluation of Community-Oriented Long-Term Care Demonstration Projects*.

uals who need services often fail to receive them. The general lack of such evidence could be interpreted in three ways. One possible interpretation is that no problem exists with regard to shortages of LTC or unmet needs for LTC. Another interpretation is that because society does not agree on the definition of terms such as "shortage," "needed," or "adequate," social scientists have no empirical definition of terms that can be measured objectively using currently available measurement tools, research techniques, and data sets. This problem confronts research on acute health care as well as on long-term care. A third interpretation is that the questions themselves misrepresent the nature of concerns over access to LTC--that the concerns may instead reflect dissatisfaction with the financial terms on which access is currently available, or subjective evaluations of the scale, appropriateness, quality, or flexibility of care under the present system.

Because interpretations of the available evidence on access to LTC vary, the discussion below considers three facets of access: the level of service availability relative to need; the quality of those services that are available; and the extent of financial protection if LTC services are needed, including the demands that are placed on informal caregivers.

Availability Relative to Need. Objective evidence on the nationwide availability of both H&CB and nursing home services, relative to the need for them, is inconclusive. Nevertheless, it has formed part of the basis for subjective judgments about these issues by some observers.

Indirect evidence about the level of access comes from geographic variation in the availability of LTC services. Although geographic variation in state funding levels does not, on its own, imply that any state is providing too much or too little care, it does imply that states vary in the availability of services relative to any uniform standard of need. In 1986, five states and the District of Columbia accounted for almost two-thirds of all Medicaid home health visits.[11] In 1985, the ratio of SNF and ICF beds per 1,000 aged people, which averaged 52 nationwide, was below 30 in three states and above 80 in three states.[12] Research indicates that, where the supply of beds is most limited, smaller proportions of the most impaired population actually reside in nursing homes.[13] Population density also affects access to formal assistance, which is less available in nonmetropolitan areas than in metropolitan areas.[14]

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[11] See Department of Health and Human Services, *Health Care Financing Program Statistics, Medicare and Medicaid Data Book, 1990*, HCFA Pub. No. 03314, Table 4.16, pp. 92-93.

Evidence might be viewed as indicating a national shortage of H&CB care services, for example, if it supported two propositions:

- That people who could live successfully in the community with the support of such services are likely to be admitted to institutions if H&CB care is unavailable; and
- That many people in institutional care could be cared for adequately in the community.

There is evidence supporting the former proposition but not the latter one.

Concerning the former proposition, one study of aged community residents in 1979 found that those whose needs were most severe were most likely to get help, and those whose needs were least severe were least likely to get it. For example, 97 percent of those needing help in eating, but fewer than one-third of those needing help in mobility, reported getting help all or most of the time. The study suggested that, rather than reflecting ready access to H&CB care, these findings may reflect the likelihood that those who need help with personal care--especially eating and transferring to or from a bed or a chair--are not able to remain in the community if they do not get the help they need.

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[12] U.S. House of Representatives, Committee on Ways and Means, *Background Material and Data on Programs Within the Jurisdiction of the Committee on Ways and Means*, 1989 ed. (1989), Table 23, pp. 241-242.

[13] See W.J. Scanlon and J. Feder, "The Long-Term Care Marketplace: An Overview," *Healthcare Financial Management* (January 1984).

[14] See B.J. Soldo, "Supply of Informal Care Services: Variations and Effects on Service Utilization Patterns" in W.J. Scanlon, ed., *Long-Term Care Service Utilization and Outcomes*, vol. 3 of *Project to Analyze Existing Long-Term Care Data* (Washington D.C.: Urban Institute, 1984), pp. 56-97.

Those whose needs are less severe, in contrast, appear able to adjust to receiving less help than they need.[15]

Reflecting the role of the family in providing help, those who were unmarried or lived alone were less likely in this study to receive needed help. Another study found that lack of informal support makes nursing home admission more likely for older unmarried women whose functional limitations are not severe.[16]

Concerning the latter proposition, definitive evidence of "premature" admissions to nursing homes and other residential forms of care is lacking, however. Such admissions may be regarded as premature if the individuals admitted would have preferred to remain at home and if available informal care, in combination with formal care costing less than the residential care, could have enabled them to do so. If the absence of H&CB care can lead to premature admissions to residential forms of LTC, then the rate of premature admissions to such facilities could represent an important complementary indicator of unmet need for H&CB care. It is difficult, however, to establish objective and comprehensive criteria for when admission to a nursing home or to another residential care facility is inappropriate. For example, available measures of mental confusion are imprecise; and criteria are lacking for the degree of confusion, or the extent of behavioral problems, that would justify admission to residential care.

After considering a broad range of information sources, the Institute of Medicine (IOM) Committee on Nursing Home Regulation stated in a 1986 report that the existing nursing home system does not provide equal access to all individuals. It referred to "widespread evidence that nursing homes actively discriminate against certain types of individuals," observing:

> State reports and empirical studies substantiate this finding of discrimination against Medicaid beneficiaries and

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[15] W.G. Weissert, "Size and Characteristics of the Noninstitutionalized Long-Term Care Population," in W.J. Scanlon, ed., *The Long-Term Care Population: Definition and Measurement*, vol. 2 of *Project to Analyze Existing Long-Term Care Data* (1984), p. 184.

[16] B. Soldo and K. Manton, "Health Status and Service Needs of the Oldest Old: Current Patterns and Future Trends," *Milbank Memorial Fund Quarterly/Health and Society*, vol. 63 (1985), pp. 286-319.

> against those with heavy-care needs. Nearly all observers agree that in almost every state there are more people seeking admission to nursing homes than there are beds available. This circumstance allows a nursing home administrator to select those applicants in the queue he or she prefers to admit. Nursing homes prefer to admit private-pay residents over public-pay residents because the Medicaid reimbursement rates are lower than charges to private-pay residents. Further, except in states that have case-mix reimbursement systems, homes have an incentive to select residents with relatively low levels of need over the heavy-care residents because those requiring less service are less costly to care for.[17]

Quality. The same IOM report concluded that the quality of care in nursing homes varies greatly. Good care can be observed in all parts of the country, under widely varying reimbursement systems, and under all types of ownership. Nevertheless, the committee expressed concern about the quality of medical and nursing care and the quality of life in many nursing homes, describing the situation in 1986 as follows:

> There is broad consensus that government regulation of nursing homes, as it now functions, is not satisfactory because it allows too many marginal or substandard nursing homes to continue in operation. The implicit goal of the regulatory system is to ensure that any person requiring nursing home care be able to enter any certified nursing home and receive appropriate care, be treated with courtesy, and enjoy continued civil and legal rights. This happens in many nursing homes in all parts of the country. But in many other government-certified nursing homes, individuals who are admitted receive very inadequate--sometimes shockingly deficient--care that is likely to hasten the deterioration of their physical, mental, and emotional health. They also are likely to have their rights ignored or violated, and may even be subject to physical

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[17] Institute of Medicine, Committee on Nursing Home Regulation, *Improving the Quality of Care in Nursing Homes* (Washington, D.C.: National Academy Press, 1986), pp. 91, 92.

> abuse. The apparent inability of the current regulatory system either to force substandard facilities to improve their performance or to eliminate them is the underlying circumstance that prompted this study.[18]

Improvements in the quality of nursing home care are intended to flow from the nursing home reform provisions of the Omnibus Budget Reconciliation Act of 1987. These provisions were a legislative response to the IOM report and are currently being implemented. They will substantially change the standards that nursing homes must meet to participate in the Medicare and Medicaid programs, and the processes by which observance of these comprehensive standards are monitored and enforced. The provisions will also eliminate the Medicaid program's distinction between skilled nursing facilities and intermediate care facilities; Medicaid "nursing facilities" will then have to meet requirements very similar to new requirements for SNFs participating in Medicare.

Extent of Financial Protection If LTC Is Needed. Much of the current concern over access to long-term care stems from dissatisfaction with the financial terms on which access is currently available--and with Medicaid's spend-down policy, in particular. Middle-income people who need significant nursing home care face unattractive alternatives. Those who can afford to purchase needed care privately may exhaust lifetime assets, reduce the living standards of immediate family members nearly to poverty levels, sell homes to avoid becoming dependent on Medicaid for their nursing home care, and dissipate intended bequests. Those less able to afford needed formal care may delay or forgo its use, placing added strain on informal caregivers (when they are available) or diminishing quality of life (when they are not).

A comparison of nursing home costs with data on the economic status of the elderly graphically demonstrates this situation. With nursing home care estimated to cost an average of $34,000 per year and with 37 percent of those admitted having stays of at least six months, for example, most older people admitted to a nursing home can expect their assets to diminish quite quickly if their nursing home stays prove to be extended. Among "aged living-units"--single individuals, and couples living without other people--in 1985, 30 percent had a net worth of $34,000 or less and 70 percent had a net worth of $81,000 or less. If only the financial assets of this group are considered, which would exclude any home equity, then 30 percent had $7,000 or less and 70 percent had $26,000 or less.[19]

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[18] Institute of Medicine, Committee on Nursing Home Regulation, *Improving the Quality of Care*, pp. 2-3.

Concern over the price of access revolves around the limited availability and use of risk-pooling mechanisms to distribute LTC costs more uniformly among those at risk. Under current policy, this situation will change only to the extent that private LTC insurance coverage increases. Although its results have been debated, one recent study concluded that:

> . . .by 2016-20 optimistic estimates are that private long-term care insurance aimed at older people may be affordable by 25-45 percent of the elderly, may account for 7-12 percent of total nursing home expenditures, and may reduce medicaid expenditures and the number of medicaid nursing home patients compared with the base case by 1-5 percent.[20]

Private insurance would presumably prove more affordable among the working-aged population, because premiums rise with the age at which insurance is first purchased. The proportion of this age group that would choose to purchase such coverage, however, remains unclear.

An additional factor affecting the affordability of LTC is that people requiring LTC assistance are more likely than others to have low incomes. For example, noninstitutionalized people needing LTC assistance in 1985 because of functional limitations were about twice as likely to have incomes below the poverty line as people not needing assistance. Only about one-fifth of those needing any form of LTC assistance reported paying for it. For those who did, however, the average cost of this assistance represented 10 percent of their average family income if they were under 65 years old and 14 percent of their average family income if they were 65 or older. For those paying specifically for assistance with personal care needs, who made up about two-fifths of those paying for any assistance, the average costs for all assistance represented 22 percent of their average family income.[21]

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[19] See Tables 22 and 26 supplementing Congressional Budget Office, "The Economic Status of the Elderly," Staff Working Paper (May 1989).

[20] A.M. Rivlin and J.M. Wiener, *Caring for the Disabled Elderly* (Washington, D.C.: Brookings Institution, 1988), p. 22.

The extent to which informal caregiving imposes demands on the caregivers can be viewed as the mirror image of the adequacy of access to formal LTC services. Informal caregivers fill the gaps left by the current structure of LTC financing. Although caregivers can receive positive benefits--a sense of being useful, companionship, and an improved relationship with the person assisted--the obligations on them can be significant. The combination of personal limitations, competing role demands, and the stresses generated by the care recipient's behavior and physical demands can create both physical and psychological strain for informal caregivers. Research suggests that the most pervasive negative consequence is emotional strain, including symptoms of depression, anxiety, feelings of helplessness and lowered morale, and emotional exhaustion.

Although it appears that the direct monetary costs of informal caregiving are usually not great, additional indirect costs can result when caregivers reduce or cease their employment. About 11 percent of caregivers report quitting their jobs to provide care and, among those who work while providing care, about two-thirds reduce their hours, take unpaid leave, or rearrange their schedules.[22] Caregivers may also accrue less in Social Security benefits as a result of not working.

Because the overall costs of caregiving can be substantial, these costs have become an important area of disagreement within the debate on LTC policy. At issue are whether families should be expected to provide the bulk of LTC and whether taxpayers should be expected to subsidize formal LTC services only to the extent that available family members cannot provide suitable informal care.

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[21] Bureau of the Census, Current Population Reports, series P-70, no. 19, *The Need for Personal Assistance with Everyday Activities: Recipients and Caregivers* (1990), pp. 7-11.

[22] See R.I. Stone, *Exploding the Myths: Caregiving in America*, U.S. House of Representatives, Select Committee on Aging, Comm. Pub. No. 99-611 (January 1987).

To What Extent Is the Problem with Access a Concern About Lack of Financial Protection?

The nature of concern over LTC costs seems relatively straightforward. The nature of concern about LTC access, however, warrants closer analysis. Despite many anecdotal accounts of shortcomings in the availability of LTC, rigorous research provides only limited evidence--summarized above--showing that significant numbers of people fail to receive needed LTC assistance.

Yet the continuing existence of concerns about access to LTC despite this lack of objective evidence also points to something more fundamental--that concerns about access reflect people's subjective evaluations. Concerns about access, for example, may reflect a range of beliefs--that available LTC services are not the most appropriate kinds; that their quality is often deficient; that the costs borne by individuals using them are unacceptably high; that reimbursement of paid providers is inadequate to fund the quality of care desired; that the system for delivering formal care services is not sufficiently flexible and integrated; or that informal caregiving imposes unreasonable demands on caregivers. These beliefs are matters of judgment involving values rather than matters purely of fact. Such matters of judgment, nonetheless, are also a legitimate focus for public policy debate. So concern about access to LTC may be interpreted, in part, as reflecting disagreement within society about what value judgments LTC policy should embody. Among the contending value judgments are those about how the costs of catastrophic LTC should be distributed between users and nonusers of LTC and among people with differing levels of privately available resources. The issues to which such disagreements give rise are explored systematically in Chapter III.

Moreover, although the lack of financial protection against costs associated with extensive LTC use may be a paramount element in concerns about LTC policy, several nonfinancial characteristics or outcomes of a LTC system might be identified as desirable from the standpoint of LTC consumers. One such outcome might be straightforward and affordable access to care that would restore or maximize independence for most users, while allowing people whose conditions make independence unrealistic to live in comfort and dignity. Closely related would be the opportunity for care recipients to live in the least restrictive environment, preferably in their own homes in the general community. Another desirable outcome might be continued participation in family, educational, occupational, recreational, and social activities. A fourth, which would be needed to achieve the first three, would be access to preventive measures that would avoid medical and social problems or delay the loss of independence. Yet another might be coordination of care from multiple providers. A final desirable characteristic might be active participation by LTC consumers (and their families, where appropriate) in all decisions affecting their treatment and lifestyle.

It is possible to design a LTC policy that would address all the concerns discussed in this section. The cost of comprehensively restructuring the current system to do so, however, would be very high. The remaining chapters of this study focus on the trade-offs between, on the one hand, modifying the LTC system to reduce financial vulnerability to costs and, on the other, the public and private costs of doing so.

CHAPTER III

ISSUES

Although the system of long-term care was almost a $60 billion industry in fiscal year 1988, no consensus has emerged on what its future structure should be or on the appropriate role of government within that structure. Most recent proposals to restructure the financing and delivery of LTC services are designed to make recipients less vulnerable financially to the extremely high costs that may be associated with these services. Most proposals also implicitly focus on the allocation of responsibility for LTC. Some would expand the federal government's role in financing, and others would shift responsibility from federal taxpayers to the private sector or to state and local taxpayers. Nevertheless, most proposals under consideration imply additional costs to the federal budget.

This chapter looks first at possible goals for LTC policy and at differing social values that are relevant to these. Next, it discusses two key groups of issues that relate to expanding financial protection and to federal costs. It concludes by considering alternative responses to these issues.

POSSIBLE GOALS FOR LONG-TERM CARE AND DIFFERING SOCIAL VALUES

Four possible goals of federal LTC policy are:

- To ensure that LTC services are available to those who need them, whether or not they can pay for them;
- To ensure that the quality of these services is satisfactory;
- To protect individuals and their families against the catastrophic costs that using LTC services may entail; and

- To avoid unnecessary federal outlays for LTC and to contain total costs.

Although goals for federal policy could also be expressed in many other ways, this formulation represents the nature of the ongoing policy debate and accounts for most of the divergent views expressed within that debate.

Policymakers pursuing these goals, like those in other social policy areas, face numerous constraints. People disagree about what is desirable, objectives are inconsistent, and available resources are limited. One reason that people disagree about what is desirable is that they hold differing values, some of which are discussed below. Another reason for disagreement is that people hold differing views about how the world works or might be made to work. An important disagreement of this kind, which is discussed later in the chapter, concerns whether a private LTC insurance market could address efficiently and satisfactorily the financial risks associated with LTC use.

Minimal Adequacy of Income and Assets or Stability of Income and Assets?

One issue concerns the relative weight that should be given to the goals of ensuring that needed services are available to those who cannot pay for them, and of protecting individuals and their families against the financially catastrophic costs that using LTC services may entail. The Medicaid program is structured so that LTC services--or at least nursing home care--are available to people who need such care but lack the resources to pay for it themselves. Medicaid therefore is already designed to address the goal of making services available. Because people remain ineligible until they have spent all but defined amounts of income and assets on health and LTC costs, however, Medicaid provides comparatively little financial protection of a person's existing income and assets.

Views differ on what weight the goal of providing financial protection should have. Those who assign it a low weight would generally favor retaining the current system's policies of requiring people to deplete most of their financial assets before becoming eligible for medical assistance and of permitting people who receive Medicaid-reimbursed care to retain only a minimally adequate income. Similarly, they would view as sufficient the recently liberalized treatment of income and assets for the spouses of people receiving Medicaid-financed nursing home care. They might therefore favor only moderate further adjustments in federal policy to improve the efficiency and effectiveness of the current Medicaid program. In contrast, those who assign the goal of providing financial protection a high weight would generally favor changes to federal policy designed to reduce the extent of means-testing and thereby to permit people needing LTC to retain more of their personal income and assets.

This issue can be framed in a broader way--should the LTC financing system be designed to prevent people's incomes and asset levels from falling below minimally adequate levels when their health status deteriorates, which is the approach adopted under Medicaid, or should it go further, seeking to keep these levels roughly stable at their earlier levels (or at least to offset partly the reductions that would otherwise occur)?

Minimal Adequacy of Income and Assets. Several arguments can be advanced for choosing minimal adequacy of income and assets as the objective. Some people consider that it would be wrong in principle, and particularly inappropriate at a time of severe federal budgetary pressure, for the public sector to subsidize LTC access for those who could afford to pay for their own care. In this view, heirs of the person receiving care would be the ultimate beneficiaries of such assistance, and protecting estates and bequests is not an appropriate goal of social policy. Moreover, avoiding LTC subsidies for groups with greater resources would allow available public resources to be targeted more precisely toward people with limited resources who need assistance most. Narrowing the pool of beneficiaries might also make possible a larger benefit for each recipient. Furthermore, those with greater resources would then have a clear incentive to provide adequately for their own possible LTC needs by saving or by joining risk-pooling arrangements.

In addition, people who advocate this approach, and who also believe that private LTC insurance could satisfactorily and effectively spread the financial risks associated with needing LTC, are likely to regard as unnecessary any further public policy concern over income and asset protection for LTC users. They suggest that individuals wanting such protection could purchase private LTC insurance and thereby achieve through private arrangements the level of protection desired.

Stability of Income and Assets. Those who advocate stability of income and assets as an implicit policy objective advance two basic arguments. One is that such stability is accepted as the implicit objective in other major areas of social policy concerned with possible risks to people's standards of living. For example, people who invoke the argument that protecting estates is inappropriate when discussing LTC rarely advance it against the Social Security retirement income and Medicare programs, which protect the estates of people eligible for them against the dissipating effects of living expenses in retirement and acute health care costs, respectively. Thus, from this perspective, public policy on health care financing for aged people contains inconsistencies. It would respond quite differently, for instance, to two elderly middle-income single people who require expensive institutional care for different terminal brain disorders--a brain tumor in one case, and Alzheimer's disease in the other. For the person with a brain tumor, Medicare would pay most hospital, medical, and hospice costs in excess of a modest deductible, regardless of the person's level of income and assets. For the person with Alzheimer's disease, however, Medicaid would not accept responsibility until, among other things, the person had spent on care all but about $2,000 in personal financial assets.

A related argument rests on a more complex concept of what is "fair." In this view, what is fair depends not only on differences in privately available resources but also on differences in people's circumstances and needs--something that other areas of social policy and tax policy implicitly recognize when they take account of such factors as family size and composition, acute health care needs, and work-related expenses. Unpredictable events--a fire that destroys a home, a collision that wrecks a car, or a sudden health crisis--can occur suddenly and create a need for significant additional financial resources for the people who experience them. People on all rungs of the economic ladder insure against a range of such risks. No one suggests, however, that it would be unfair for people with large incomes or assets to submit claims on their fire or automobile insurance, because their economic status is considered irrelevant in this context. Such insurance is designed to respond to unpredictable increases in needs. By doing so, it minimizes the impact that an adverse event would otherwise have on a person's normal standard of living--that is, it helps to maintain a stable standard of living.

People holding this view contend that the need for additional resources to meet the costs of LTC is analogous to the need for additional resources to rebuild a home destroyed by fire. For those who also believe that private LTC insurance could not offer a satisfactory and effective mechanism to spread the risk of needing LTC, criticizing publicly sponsored arrangements that would do so on the grounds that they would assist people above the poverty line is as inappropriate as criticizing the payment of a fire insurance claim to such a person. Just as fire insurers will use premiums of a low-income person whose house remains safe to help rebuild the house of a higher-income person whose house burns down, so social insurance arrangements for LTC might use the contributions of a low-income taxpayer who does not need LTC to help finance care for a higher-income person who does.

One LTC System or Two

Another normative issue in structuring LTC subsidies is whether the LTC delivery system should treat all LTC recipients in a uniform way or whether instead it should treat differently people with subsidized access to LTC by providing them with a different standard of care or identifying them as recipients of subsidies. Current policy results in different treatment for those receiving Medicaid-subsidized LTC; and some other areas of social policy, such as housing policy, also treat differently those who receive public subsidies. Some people regard such differential treatment as an advantage because it can discourage participation in subsidy programs and reduce public-sector costs. Others consider it a disadvantage because they perceive it as demeaning and conducive to assistance that is of an unsatisfactory quality.

Geographic Uniformity

A further normative issue in structuring LTC subsidies is whether any new LTC financing system should be nationally uniform, should require states to design systems embodying national standards, or should give states complete autonomy to design their own systems. Whether primary responsibility for LTC policy and for the design of LTC delivery systems should rest with the federal government or with the states is largely a matter of political and social values. Nevertheless, pragmatic considerations are also relevant. For example, imposing uniformity on a system that is already diverse could prove difficult. Yet, if states established different LTC systems in which, outside the context of Medicaid, LTC access depended partly on prior contributions to the system's financing, then people who moved to a different state (for example, at retirement) might be disadvantaged.

Competing Fiscal Priorities

The demographic changes projected to occur in coming decades will ensure that, under current law, outlays on LTC will grow faster than the federal budget as a whole. Any policy changes that expanded the range of people or benefits covered would result in still greater increases in spending. Increased public financing of LTC, however, must compete with other urgent fiscal priorities:

- The existing federal deficit;
- The rival health policy concerns of a diminishing Medicare trust fund, of more than 30 million Americans without insurance for acute health care (most of them below retirement age), and of the growing number of people with Acquired Immune Deficiency Syndrome (AIDS); and
- A range of policy concerns in areas other than health.

Views differ concerning the relative priority that should be accorded to these competing objectives.

ISSUES RELATED TO EXPANDING FINANCIAL PROTECTION

The major problem facing those who need LTC services, and their families, is the potentially devastating costs of services required over an extended period. Providing financial protection against these costs has been a focus of most recent proposals to change LTC financing. Reducing financial vulnerability, however, has different implications for access, quality, and cost, depending on the form and financing of the proposed restructuring.

This section discusses three key issues that must be addressed in designing policies that would extend financial protection for LTC. These are:

- Alternatives for increasing financial protection;
- Alternatives for benefits to be financed; and
- Alternatives for targeting limited funds to specific groups.

A fourth issue--allocation of responsibilities within the LTC system--is implicit in the first three.

Alternatives for Increasing Financial Protection

What alternative approaches are available if policymakers wish to expand financial protection for LTC users and their families? If the potential costs of LTC are expected to be very high, public policy could respond by encouraging greater personal saving, establishing risk-pooling mechanisms, arranging resource-related subsidies, or combining these strategies.

Incentives to Save. Incentives to save are intended to augment personal resources and so to promote self-sufficiency in purchasing needed LTC services. Under the widely discussed proposal for an individual medical account (IMA) modeled on the individual retirement account (IRA), for example, funds that were accumulated in an IMA dedicated to LTC or medical expenses would have tax advantages similar to those for investments in IRAs. Funds not used to purchase LTC or medical services would become part of the individual's estate.

Advocates of incentives to save contend that, at an individual level, incentives would encourage people to provide privately for their LTC needs if they could afford to do so, thereby reducing the demand for publicly financed LTC. At an aggregate level, they claim that private saving, investment, and economic growth would rise. Thus, they reason, by making additional economic resources available, these incentives could help make possible the LTC services required. Moreover, additional savings could be managed and invested through the private sector.

The first two claims, however, are open to challenge. A recent report by the Department of the Treasury concluded "that IMAs would be too narrowly focused to be a broadly attractive saving incentive" and that those people induced to participate would be likely to have high incomes.[1] The claimed aggregate benefits, moreover, presuppose that IMAs would increase private saving and total saving. A net increase in saving, however, cannot be counted on. IRAs reduce the present value of an individual's lifetime tax liability. So, to increase national saving, IRAs would have to raise private saving by more than they reduce net federal revenues. Economists disagree about whether IRAs had this effect, even when the accounts were widely available before 1986. Most empirical evidence suggests that individuals are not very responsive to higher after-tax rates of return on saving. Moreover, a major portion of the tax advantages from IRAs may accrue to private saving that would take place without the IRA.[2] The level of saving for narrowly defined purposes such as LTC might be even less sensitive to higher rates of return.

Another disadvantage of subsidies for private saving for LTC is that their impact on reducing financial vulnerability would be delayed

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1. Department of the Treasury, *Financing Health and Long-Term Care: Report to the President and to Congress* (March 1990).

2. Congressional Budget Office, "The IRA Proposal Contained in S. 1682: Effects on Long-Term Revenues and on Incentives for Saving," Staff Memorandum (November 2, 1989).

because accumulating additional savings takes time. Moreover, some people might not wish to earmark savings solely for care they may never need and might prefer insurance as a less expensive and more flexible means to the same goal. Others who saved for LTC needs might find that their savings were less than the cost of needed care and so would still face a substantial financial burden unless complementary measures existed. So the strategy of encouraging private saving would probably not be effective as an approach to increasing financial protection for LTC users.

Risk-Pooling Arrangements. Another approach to providing financial protection against LTC costs would greatly expand risk-pooling arrangements, such as LTC insurance or prepaid LTC. Social insurance also involves risk-pooling transfers, but is discussed below because it typically combines them with resource-related transfers. Risk-pooling arrangements effectively transfer resources from people who do not use LTC to people who do, while providing all participants with the benefit of financial protection against LTC costs. Although risk pooling is central to arrangements for financing acute health care, it has played only a minor role in LTC financing to date. Whether it should play a larger role, what form any risk pooling should take, and what role government should play in risk-pooling arrangements are key issues for LTC policy.

Voluntary risk pooling works best when service costs are high relative to the average income for people requiring services, when only a small proportion of the population needs the services, and when that proportion is known but the specific individuals who will need services are not known. On this basis, many conditions that result in LTC needs seem insurable, subject to two main qualifications:

- Although functionally disabling conditions can be demonstrated for many individuals, determining the form and scale of LTC service needs to which these conditions give rise typically involves elements of judgment. Moreover, consumers would make more use of LTC services if they paid only part of their costs than if they paid their full costs. To date, insurers have dealt with these problems primarily by providing benefits in the form of indemnity payments--flat cash amounts.

- LTC insurance premiums would need to be set even though information relevant to establishing expected lifetime LTC costs by age and sex--the appropriate basis for setting insurance premiums--would continue to be unavailable. In particular, there is uncertainty about the actuarially fair premium structure for LTC risk-pooling arrangements because changes over several decades in health technology, health-related behavior, mortality, morbidity, and inflation rates are hard to foresee. Also, any change in public policy would affect LTC-related private behavior and thus the actuarially fair premium structure.

A small but rapidly growing market for private LTC insurance has emerged in recent years. Reportedly, 1.65 million policies had been sold by June 1990. Nearly all were individual or group association policies, with the average age of purchasers being around 70. Where group policies are available through employers, the employer typically makes no contribution to the cost of premiums. Benefits vary substantially and the policies include many restrictions, but newer policies tend to be more flexible and to have fewer restrictions. For example, unlike earlier policies, most newer policies do not require that a covered nursing home stay be preceded by a three-day stay in a hospital. Also, home health care benefits are now more commonly offered (generally subject to physician certification and medical necessity), and many policies now offer benefit adjustments that provide partial protection against future inflation.[3]

One policy issue that the voluntary risk-pooling approach raises is whether most people could afford to participate--particularly people entering into the arrangements at older ages, because actuarially fair premiums would increase with the age of first participation in the risk pool. For an insurance policy offering up to four years of benefits at $80 a day for nursing home care and $40 a day for home health care

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[3] S. Van Gelder and D. Johnson, "Long-Term Care Insurance: A Market Update," *Health Insurance Association of America Research Bulletin* (January 1991).

(both subject to inflation adjustments), and with a 20-day deductible period, the estimated average annual premium in 1990 was $658 at age 50, $1,395 at age 65, and $4,199 at age 79.[4]

Another pair of issues is whether adverse selection would create serious obstacles to establishing voluntary risk-pooling arrangements open to everyone and, if so, whether this should be viewed as a problem. People who know they are likely to need LTC could be expected to join voluntary LTC risk-pooling arrangements with open membership in disproportionate numbers. This could make the insurance arrangements unstable and ultimately not viable by driving up premiums over time and inducing people at lower risk to drop out of the risk pool.

Alternatively, if high-risk individuals were to be excluded from coverage through medical underwriting--which would limit eligibility using criteria based on medical, physical, or mental conditions that imply a current or likely future need for care--then voluntary LTC risk-pooling arrangements would deny the opportunity for protection against financially catastrophic LTC costs to the group most needing it. Virtually all current LTC insurance policies use medical underwriting or indirect methods to exclude high-risk individuals or to limit benefits for preexisting conditions. Nevertheless, for people who are able to afford the premiums and who do not have preexisting conditions that imply a potential need for LTC, such insurance could provide the opportunity to obtain financial protection against the costs of LTC through the private sector. This coverage could substitute for additional government measures to provide such people with increased financial protection against LTC costs.

A further issue is whether risk-pooling arrangements could develop satisfactorily through private market processes alone, or whether government would need to be involved. This would depend partly on two factors. One is whether the risk-pooling arrangements would initially be intended to cover people's existing needs for LTC. The other is whether individuals, in deciding whether to buy LTC insurance, would disregard the benefits that their becoming insured would have for other people.

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[4] Van Gelder and Johnson, "Long-Term Care Insurance."

Establishing risk-pooling arrangements that covered care for preexisting conditions would, from the outset, assist people who already required care or who had conditions that implied a future need for care. Establishing arrangements that did not cover preexisting conditions, however, might also lead ultimately to substantial coverage of the whole population if most people chose to join risk-pooling arrangements at the earliest possible age, before disabling conditions were likely to have developed. In practice, the only risk-pooling arrangements that would be likely to cover preexisting conditions are social insurance arrangements with universal coverage or mandated employer-based insurance that is "community rated" (that is, the premium each person pays is based on the expected average claims and administrative costs for the population as a whole or for an entire age group and is not affected by whether an individual's health status or prior claims experience is better or worse than average). Voluntary private insurance could be expected not to cover care for preexisting conditions because of adverse selection.[5]

People might buy less private LTC insurance than economic theory would suggest is needed to reflect efficiently the preferences of fully informed consumers. For several reasons, their decisions might not accurately reflect all of the benefits and costs to themselves and others.

- In deciding whether to purchase, people might not take full account of the value that their potential informal caregivers would place on their having insurance.[6]

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5. Actuarially fair insurance could cover care for preexisting conditions and remain viable only if individuals with preexisting conditions were no more likely than others to join the group that pooled risks. Voluntary private LTC insurance sold on an individual basis could not viably cover care for preexisting conditions because separate risk pools involving lower premiums would develop for people without such conditions. In practice, voluntary private LTC insurance sold on a group basis would also be unlikely to cover care for preexisting conditions if the groups were defined in such a way that any member of the population could join.

6. See, for example, M.V. Pauly, "Optimal Public Subsidies of Nursing Home Insurance in the United States," *The Geneva Papers on Risk and Insurance*, vol. 14, no. 50 (January 1989), pp. 3-10. Pauly argues that it may be efficient, from an individual's perspective, for parents who wish to be cared for at home, rather than in a nursing home, to leave their assets at risk so that children will have more incentive to provide informal care.

- Because Medicaid includes a form of catastrophic LTC insurance financed by taxpayers, some people might choose either not to buy private LTC insurance or to buy less of it.

- Gaps in available information would make both the benefits and the costs of private insurance uncertain for consumers. Concerning benefits, companies might go bankrupt or might use legal technicalities to deny benefits to individuals in unforeseen ways. Most policies offer at most only partial protection against inflation, so that the ability to purchase LTC benefits might be inadequate when care is needed. Public policy might change in ways that made private insurance redundant or its benefits less valuable. Concerning costs, companies might raise premiums for all insurees in a class.

- If younger consumers systematically underestimate either their likelihood of needing LTC or the consequences for their well-being of needing care they could not afford, they could be expected to buy less LTC insurance than if they based their decisions on more realistic estimates.

- If premiums exceeded actuarially expected LTC costs by a larger margin than necessary, then some consumers who could potentially benefit from fair insurance might forgo buying the insurance products available. For example, marketing and administrative costs could be higher under voluntary private insurance than under alternative risk-pooling arrangements.[7] Insurers might also respond to information gaps by basing premiums on unduly conservative assumptions.

Overall, these considerations suggest that private LTC insurance markets are subject to a degree of market failure--that is, they do not allocate personal resources in a fully efficient way and, as a result, people could be expected to purchase too little insurance against the financial risks associated with LTC use.

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[7] The model LTC insurance standard developed by the National Association of Insurance Commissioners recommends that at least 60 percent of revenue from premiums for private LTC insurance policies for individuals be paid out in benefits. This implies that consumers would have to spend $1.67 for each dollar of "pure" insurance coverage. The degree of risk-aversion among potential consumers may not be sufficient to support such a market.

People who judge that risk-pooling arrangements could not develop satisfactorily through private-market processes alone (or who consider that universal access to LTC insurance coverage would not be possible under this approach because of adverse selection) might wish governments to do more than simply allow the small but growing market for private LTC insurance to continue developing. One alternative would be to mandate that employers sponsor LTC insurance coverage for all employees. This might be achieved, for example, either through voluntary group coverage for employees (including coverage during their retirement) and for their dependents, through mandatory coverage with similar scope, or through integration of LTC insurance with the existing system of pensions and retirement income. The same policy approaches might also appeal to those who wished to see costs of government-mandated LTC insurance kept off-budget. A difficulty for this position is that, if employers contributed to the cost of insurance, it would add to their existing retiree health care costs, whereas if employers did not contribute, participation in voluntary insurance arrangements might result in only limited insurance coverage among the population.

Various other options also exist for the role of public policy in relation to risk pooling. These options include clarifying or changing the tax treatment of LTC insurance companies' reserves or of their payments to policyholders; regulating the private LTC insurance market more closely than at present; insuring policyholders against the failure of LTC insurance companies, as has been done--at a high cost to taxpayers--in relation to financial institutions and pension funds; supporting private reinsurance arrangements for LTC under which LTC insurers could spread the underwriting risks that they bear; providing preferential tax treatment for private expenditure on LTC risk pooling; and establishing social insurance arrangements for LTC.

Resource-Related Subsidies. Subsidies that are related to a person's resources, if used alone, make people with limited resources eligible for LTC services at subsidized prices, with a policy on user charges specifying how price subsidies relate to the number of services used, the cost of each service, and the individual's level of privately available resources. This strategy underlies the current structure of LTC financing through the Medicaid program. Resource-related subsidies, which reflect a distinction between a person's need for a service and the person's need for a subsidy to gain access to the service, can target subsidies toward those in relatively greater financial need.

Different types of income, asset, and means tests can be used to vary the net benefit that a person receives under a program as the person's level of privately available resources (however defined) varies. Additional resources above some threshold reduce the net benefit in each case, but by different amounts. In all states, Medicaid incorporates an asset test under which all people whose countable assets exceed the specified asset threshold are ineligible for medical assistance. Medicaid programs in different states also use two of three possible kinds of income test.

- States without medically needy programs for LTC under Medicaid--the so-called "209(b) states"--use a "sudden-death" income test under which a person is ineligible for any LTC assistance in any month when income exceeds the special income threshold by even a single dollar.
- States that have medically needy programs under Medicaid use a "dollar-for-dollar" income test that reduces the net subsidy by one dollar for each dollar of privately available income above the threshold, provided that the private income has been spent on relevant care.
- Under a "sliding-scale" income or means test, which is not used within Medicaid, the net subsidy would be reduced by less than a dollar for each dollar of privately available resources above the threshold.

The three approaches have different implications for whether resource-related subsidies would reverse the relative economic statuses of two people with the same LTC needs, for the incentive for people to keep their level of resources below the relevant threshold, and for the extent to which all of a program's net subsidies would be targeted toward people below the resource threshold for eligibility.

Combined Strategies. The preceding strategies can be combined in various ways. Although some have proposed combining savings incentives with risk-pooling arrangements, most such discussion focuses on combining risk-pooling arrangements with resource-related subsidies. The latter strategy is the basis for proposals to subsidize private LTC insurance for low-income people. It is also the basis of Medicare financing of health care, insofar as Medicare provides all eligible people with access to the same set of benefits and finances most benefits with a combination of payroll taxes and general revenue that together are more progressive than flat-rate, actuarially fair premiums would be.

Combining risk-pooling arrangements with resource-related subsidies creates for public policy an additional choice--whether to subsidize LTC services themselves or to subsidize risk-pooling arrangements established for LTC. Traditionally, public policy has perceived a single problem--people whose LTC service needs exceed their resources--and it has responded through Medicaid by subsidizing LTC services for such people. An alternative view perceives people whose LTC service needs exceed their resources as the common element in two different problems that invite different policy responses. One problem involves people with average incomes but unusually high LTC needs and could be solved by risk pooling through insurance or prepaid care plans. The other problem involves people with average LTC needs but unusually low incomes and could be solved by ensuring that people have sufficient resources to pay the insurance premiums or LTC prepayments involved. In effect, the latter view defines the benefit provided by the program not as the receipt of particular LTC services but as the option to receive such services if they should become needed. The implication is that all people covered by the program would receive the same benefit--financial protection against LTC costs--regardless of whether they developed a need for LTC services themselves.

This additional choice about what could be subsidized in turn creates an additional choice about how subsidies could be delivered. Because every dollar of benefits must be financed in some way, the distributional impact of any program that provides resource-related subsidies would depend as much on its financing as on its benefits. Subsidies within such a program could be structured not only by linking the price of services received to privately available resources, but also by linking tax payments that finance the program to privately available resources. Consider, for example, a LTC program that gave all people the same access to needed LTC services and that was financed by progressively structured tax payments from all participants. Then, among people needing LTC, those with greater resources would receive smaller net subsidies (or would make larger net contributions) than those with fewer resources. At the same time, among people with the same resources, those needing LTC would be treated more favorably.

If subsidies are structured by linking the price of services to privately available resources, subsidies would be provided on the service-delivery side of the LTC system. If subsidies are structured by linking tax payments that finance the program to privately available resources, subsidies are provided on the financing side. Using a combination of these approaches might sometimes have appeal, especially because individuals' relative economic positions can vary significantly over time. For example, resource-related tax payments could be used to achieve progressive financing of arrangements that would provide financial protection against LTC costs, and resource-related prices for services could be used to establish a structure of copayments that could be subject to resource-related ceilings and that could help to contain costs.

Alternatives for Benefits to be Financed

A second major issue in the debate on reducing financial vulnerability for LTC concerns the range of services that would be covered by any arrangements to improve protection. LTC experts agree that a continuum of LTC services must be available if people are to receive the most appropriate services. At issue are three questions of balance within the overall mix of LTC services. One concerns the balance between residential and nonresidential forms of care. Another relates to the balance within residential forms of care between nursing homes and other types of facilities--such as continuing care retirement communities, personal care homes, Section 202 supported housing, and board and care homes--that offer supportive or therapeutic care in a less restrictive setting.[8] The third involves the balance within nonresidential forms of care among various in-home and community-based services.

This issue is of particular importance because many observers think that the current system biases choices among types of care. Current financing and subsidy arrangements differ substantially across services in the LTC continuum. Some argue that these arrangements can sometimes limit effective access to the most appropriate services by biasing care choices toward more heavily subsidized services. In this view, current LTC financing favors nursing home care over less restrictive forms of residential care (such as personal care homes) or H&CB services for chronic conditions. Among H&CB services as a whole, it favors skilled and rehabilitative services over those that support independent living. In addition, it favors care for acute conditions over care for chronic conditions.

Others argue that nursing home care is the service typically needed by the most functionally dependent people. Moreover, determining when care is truly necessary is easier for nursing home care than for some other LTC services. Furthermore, few people would be likely to enter a nursing home if they had acceptable alternatives. Also, current limitations on Medicaid funding for services other than nursing home care have presumably helped to limit federal costs under Medicaid.

Balance Between Residential and Nonresidential Forms of Care. Many people consider that the present mix provides too little nonresidential care. Advocacy for expanded LTC programs has often been on behalf of people who need ongoing H&CB services to continue living in the community. Opinion polls show clearly that people would rather receive needed LTC in their own homes than in nursing homes. Among aged people with LTC needs, four out of five live in the community. Of those living in the community, about 75 percent receive only informal care, 20 percent receive both informal and formal (that is, paid) care, and only about 5 percent rely solely on formal care.[9] In contrast, nearly 80 percent of all LTC expenditure is for nursing home care.

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[8] Section 202 of the Housing Act of 1959, as amended, authorized direct loans to nonprofit organizations sponsoring the construction and management of rental housing for elderly or handicapped people. The Cranston-Gonzalez National Affordable Housing Act, enacted in 1990, replaced the Section 202 direct loan program with capital grants for supportive housing that is designed to meet the physical needs, or need for services, of elderly people with very low incomes or of people with disabilities.

Most observers would agree that, if people who do not need the level of care provided in a nursing home or other residential LTC facility could continue to live with appropriate LTC support in a community setting, their quality of life would in general be enhanced. Nevertheless, providing such H&CB support can be expensive, especially if the person is highly dependent, lives alone, and receives limited informal care. When such care would be available only if it is subsidized, the critical policy question is the extent to which society is prepared to pay more for H&CB care that may increase quality of life for its frail and functionally dependent people.

Balance Among Alternative Forms of Residential Care. Some performance critics consider that nursing homes inappropriately dominate the residential care sector and that people unable to live independently in the community with H&CB support risk being admitted to a nursing home, even though they may not need that level of care. For such people, the argument goes, quality of life and independence could be enhanced if residential facilities less restrictive than a nursing home were more widely available. Contributing to this situation is that, in general, Medicare and Medicaid do not reimburse residential LTC services unless they are provided in nursing facilities. These restrictions, which are designed to target subsidies toward needed care and thus to limit program costs, unnecessarily increase costs for some who receive nursing home care and exclude others from required care in a less dependent residential environment such as a personal care home.

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[9] K. Liu, K.G. Manton, and B.M. Liu, "Home Care Expenses for the Disabled Elderly," *Health Care Financing Review*, vol. 7, no. 2 (1985).

Subsidizing LTC services in residential facilities less restrictive than a nursing home might facilitate innovative forms of residential care and help to bridge the gap within the continuum of subsidized care between H&CB care and nursing home care. Nevertheless, expanding subsidies for less restrictive forms of residential LTC would not necessarily reduce total public spending on LTC and might well raise it. The issues involved parallel those relevant to the choice between residential and nonresidential forms of care. What would be the relative costs of the two forms of residential care? To what extent would publicly subsidized care in these facilities substitute for publicly subsidized care in nursing homes? To what extent would the availability of such facilities attract into them people eligible for subsidized care who would otherwise have continued living in their own homes without receiving subsidized formal LTC services? Answers to these important questions are currently unavailable.

An alternative approach would break the link between subsidies for care and subsidies for accommodation that is implied by reimbursing nursing home care and accommodation as an overall package. Breaking this link could mean subsidizing through LTC programs only the costs of care, but doing so regardless of the residential setting--that is, whether the LTC services were provided in a nursing home, a personal care home, Section 202 supported housing, some other form of residential care setting, a community-based facility, or an individual's private home. Under this approach, any subsidies for accommodation costs would represent another dimension of housing policy that would need to be integrated with other elements of housing policy.

This approach would facilitate innovation and flexibility in the delivery of LTC services and could allow some people to receive more appropriate care or to receive care in a preferred setting. It could further fragment both policy responsibility for LTC and the financing of LTC, however. It would also have unpredictable effects on total and public LTC costs and would disrupt financial patterns in the nursing home industry.

Balance Among Alternative Forms of Nonresidential Care. Among alternative forms of nonresidential care, an appropriate balance must be struck between services for post-acute care, which are mainly medically oriented (such as skilled therapy, rehabilitation, and nursing), and ongoing services for people with chronic conditions, which in general are less medically oriented (such as chore services and assistance with personal care and meals).

On the one hand, giving priority to people who need relatively short periods of LTC during convalescence or rehabilitation would help them to regain their capacity for independent living, thus possibly avoiding the need for more extended LTC, and to retain sufficient assets so that they and their families could remain economically independent. It would also facilitate the growth of a private LTC insurance market for catastrophic LTC costs if insurers were willing to offer such policies at what are regarded as reasonable premiums for the admittedly open-ended risks of the current system. The principal drawback of this approach, however, is that it would provide little financial protection against catastrophic costs resulting from lengthy stays in nursing homes.

On the other hand, giving priority to people who need extended LTC would address the potentially catastrophic costs associated with prolonged use of formal LTC, especially in a nursing home. It would also help avoid or reduce problems that can accompany extended caregiving in the community for functionally dependent people--inadequate or insufficient care, extraordinary demands on caregivers, and premature admission to residential care. Moreover, it would avoid using the available public funds for LTC to finance post-acute care that the acute health care system might otherwise provide or finance. Furthermore, it would assist private LTC insurers to offer policies under which their maximum losses per policy were effectively limited, which might encourage growth in the supply of such insurance. The major drawback with this approach, however, is that people requiring physical therapy or other forms of rehabilitative care that could restore the capacity for independent living might fail to receive this care because of funding limitations.

Alternatives for Targeting Limited Funds

If the available level of public funds limits those who will receive financial protection against LTC costs, priorities must be established to define target groups using criteria such as age or level of functional limitations. Another possible criterion is people's level of privately available resources, but the basic issue here--whether the LTC financing system should foster minimal adequacy or stability of income and assets when a person's health status deteriorates--has already been discussed. Similarly, issues raised by yet another possible criterion--duration of the need for services--were just discussed in relation to the balance among alternative forms of nonresidential care.

Target Groups Based on Age. Although people of any age may require LTC, it is predominantly used by older adults. Limiting available funds for LTC to aged people would make the costs and consequences of any new program more predictable because much more is known about user characteristics and patterns of service use for older adults than for working-aged adults and children. Moreover, LTC policies for working-aged adults and for children with disabilities raise enough additional or different issues--for example, work incentives, habilitation and rehabilitation, education, and family rather than individual income support--that it might be preferable to develop LTC policies for them separately.

Several considerations, however, argue against age-based limitations. First, many people who are not old already receive subsidies under current policy. Also, younger people who have LTC needs and experience the financial consequences may find that their needs and financial burdens are just as great as those among aged people. Next, working-aged people with disabilities would normally have had less time to accumulate assets as a hedge against risks like disability. Moreover, aged people as a group may receive more assistance through social policy than do working-aged adults with disabilities as a group. Furthermore, developing separate policies for people with disabilities who are not old would not necessarily reduce total public costs for LTC. Finally, maintaining the focus of public policy on LTC as a generic service would avoid the potential inefficiencies to which multiple age-based target groups could give rise.

Target Groups Based on Level of Functional Limitations. Any LTC program can be expected to incorporate disability criteria within its eligibility conditions. The relevant issues are therefore how to define and measure disability, how restrictive to make the criteria, how to implement them, and how to relate them to other criteria and processes for establishing eligibility and determining the benefits to be received.

Defining Disability. There is now substantial consensus that the definition of disability within LTC programs should focus on limitations in an individual's ability to undertake normal daily activities independently, rather than on illness or the presence of physical or mental impairments. Accordingly, assistance with financial protection against LTC costs could also be limited to groups who display a specified level of functional limitations.

Measuring Disability. Nevertheless, because functional limitations can result from a range of causes--physical impairments, dementia, mental illness, and chronic illness--measuring functional limitations is a skilled process that is not always straightforward and that involves elements of judgment.

Scales for activities of daily living and instrumental activities of daily living are primary measurement tools. Although special equipment sometimes overcomes limitations, assistance from another person is often required. Thus, the numbers of ADLs and IADLs for which people need human assistance are informative indicators of their need for LTC.

Some people who need LTC do not exhibit ADL limitations, however. For example, many residents of nursing homes display no ADL limitations although their admissions would generally have been considered warranted by cognitive impairments, such as dementia or mental illness, or by behavioral disorders. Mental confusion is typically measured from answers to simple factual questions or, if this is not feasible, from reports by caregivers. A need for supervision is sometimes inferred from difficulty with certain IADLs, such as managing finances or taking medications.

For some conditions--for example, cognitive impairments, mental illness, and psychiatric conditions--there are serious inherent difficulties in specifying eligibility criteria that would be clinically valid, administratively workable, and not subject to abuse or "gaming" by people who wished to establish eligibility for costly services or by providers who wished to ensure that they were reimbursed.

Restricting Eligibility. Eligibility criteria based on functional limitations can be made more or less restrictive. For example, raising the threshold number of ADL limitations would restrict eligibility to a more dependent population. Research suggests that raising the threshold from two ADLs out of five to three ADLs out of five markedly raises the average degree of dependence.[10]

Because some people with moderate dementia do not have ADL limitations, eligibility criteria that omit an explicit criterion covering functional limitations associated with cognitive impairment will be more restrictive than those that include such a criterion. The argument for including such a criterion is that extended caregiving for people with even moderate dementia can exhaust the physical and emotional resources of even highly committed informal caregivers. At this point, a form of residential LTC may be the only viable option. The argument against including such a criterion is that measurement tools for cognitive impairment are more rudimentary than those for physical impairment. Their application would thus be less precise, and their use as administrative criteria that create an entitlement to expensive LTC services would be more vulnerable to abuse.

Role of Eligibility Criteria. If target groups are defined using criteria based on assessed levels of functional limitation, one important issue is whether these criteria are used as a screen to define the maximum covered population (that is, to impose a ceiling on eligibility) or as a threshold that creates a legally enforceable entitlement to assistance (that is, as a floor under eligibility). Current state practices differ from some recent policy proposals in this regard.

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10. See R.I. Stone and C.M. Murtaugh, "The Elderly Population with Chronic Functional Disability: Implications for Home Care Eligibility," *The Gerontologist*, vol. 30, no. 4 (1990), pp. 491-496.

State-administered LTC programs that operate within relatively fixed budgets routinely use such criteria as a screen to determine who may have LTC needs that should be assessed more comprehensively and to help allocate available LTC resources among the individuals seeking assistance. Within this budget-constrained environment, the use of such criteria has not proved to be controversial.

If such criteria were made the basis for defining an entitlement that was enforceable under administrative law, other issues might arise. In particular, because assessment of functional limitations is based largely on self-reports or demonstrations by the individual seeking assistance, criteria developed for clinical and research purposes might yield a higher prevalence of measured disability if used administratively to authorize access to expensive care. Other issues would include what fiduciary responsibilities to taxpayers those undertaking the assessment would have, how these responsibilities would be enforced, and what other mechanisms to contain costs would be incorporated in the program's structure.

ISSUES RELATED TO FEDERAL COSTS

Any change in long-term care policy that reduces financial vulnerability could be expected to increase total expenditures for these services. The impact on federal spending would depend upon the role that the federal government accepts in the structure of these new policies and the explicit cost-containment rules incorporated into the changes in financing and delivery. This section discusses the implications for federal costs of inconsistencies among LTC policy goals that give rise to trade-offs. It also covers issues involving transferring financial responsibility for LTC to the states or to the private sector.

Trade-offs Arising from Inconsistent Policy Goals

Although the basic goals of LTC policy may be individually desirable, they are mutually inconsistent--a dilemma LTC policy shares with acute health care policy and other social policy areas. In particular, the goal of ensuring that services are available to people needing them regardless of ability to pay and the related goal of improving financial protection for users of LTC services conflict with the goal of containing federal outlays. (Policies such as medical research and health promotion that could reduce total demand for services may make this tradeoff less severe, however.) Similarly, although some improvements in LTC quality might be achievable within the existing level of resources, the goal of ensuring that the quality of services is satisfactory will in general conflict with the goal of containing federal outlays.

Financial Protection for Users Versus Federal Costs. Neither private financing mechanisms nor government programs provide assistance that is generally available, regardless of income and assets, for groups requiring LTC services of extended duration. Reducing financial vulnerability by expanding "third-party payment"--whether by risk-pooling organizations, by governments, or as part of restructured saving arrangements--might raise LTC costs, including those paid through government programs. Risk-pooling arrangements would reduce out-of-pocket costs for needed care, and so would encourage consumers to use more LTC services or to substitute formal for informal services.

More generally, if LTC financing arrangements were substantially altered to improve financial protection for users, people would probably respond by changing the amounts and kinds of LTC services that they use in ways that would increase overall costs. Moreover, more generous funding of formal LTC services might lead over time to a change in prevailing attitudes that rendered formal LTC--and particularly formal H&CB care--more acceptable, in the eyes of those needing care and of their families, as an alternative to informal LTC. Such a change in attitudes might lead to gradually increasing substitution of formal for informal care, as has already happened in the somewhat analogous case of child care. In addition, there might be increased substitution of formal H&CB care for nursing home care because it also enhanced quality of life. Although these behavioral responses are likely, however, no reliable means currently exist to forecast their overall magnitude. Consequently, action to improve financial protection for users that involved an additional financial role for taxpayers would probably not only increase federal outlays but also make their level less predictable.

As total demand increased in response to reduced out-of-pocket costs for individual users, the price of services would rise if their supply were limited, as is likely in the short run. Any increases in the price of LTC services would be likely to raise federal program costs directly. Price increases could also have indirect effects by increasing the proportion of the population who became impoverished because of personal outlays on health care and LTC. Providers reimbursed under fee-for-service arrangements would also face incentives to provide more and better care, because doing so would increase their incomes and offer them the satisfaction of serving their clients better. If regulatory controls or shortages of skilled providers caused supply to grow more slowly than demand, then price increases would continue over a longer period.

Quality of Care Versus Federal Costs. Efforts to improve quality could have significant effects on total and federal LTC costs. For example, raising Medicaid reimbursement levels for nursing homes might promote quality, particularly in states where these levels are well below the private-sector charge, but it would also raise federal and state Medicaid outlays. The increased unit price of care would directly raise spending, and the higher reimbursement levels could make Medicaid patients more attractive clients to nursing homes, possibly resulting in higher admission rates and longer stays. In addition, if quality increased because of higher reimbursement rates, some individuals who were struggling to remain at home rather than enter a low-quality institutional setting might become willing to seek admission to a nursing home.

The impact of the recent regulatory changes that are intended to ensure adequate quality of care in nursing homes cannot be assessed until after they have been fully implemented. To the extent that they improve the average quality of care and establish a satisfactory minimum level of quality for publicly subsidized services, they might affect the costs of care. In general, if providers are using resources efficiently, it will be more expensive to provide higher-quality care than lower-quality care. Alternatively, if reimbursement levels do not also rise to compensate nursing homes for these costs, then access may become a greater problem, or quality may deteriorate in dimensions of care that are not subject to direct oversight.

Ensuring quality and containing costs can be inconsistent goals in other ways as well. For example, adopting prospective or capitation reimbursement of providers to help contain costs could create incentives to reduce quality. Incorporating restrictions within government programs to help control program costs--for example, by subsidizing residential LTC only if it is provided in a nursing home--might reduce the flexibility and thus, in some cases, the appropriateness and hence the quality of available care.

Moreover, if measures to increase financial protection against LTC costs reduced the effective price to consumers of these services, consumers might choose to use some of the resulting increase in their disposable incomes to purchase services offering higher quality or more amenities. If this occurred, the industry could respond by providing higher quality and more amenities and then charging higher prices for these enhanced services. Because it is difficult to break down price into the costs of the basic service and of the amenities and enhanced quality, the average unit of service probably would shift over time toward a more expensive, more attractive, and higher-quality product. Controlling this phenomenon is difficult, as has been seen in the Medicare program and under private insurance, although flat-fee payments per unit (for example, Medicare's prospective payment system for hospitals) and capitation arrangements offer some possibilities for containing the tendency to seek higher quality when price declines.

For public policy, part of any response to the trade-offs outlined above might involve designing new financing arrangements that could be implemented in discrete stages. In this way, policymakers could retain reasonable control over the level of public outlays while any new arrangements were introduced.

Implications of Transferring Financial Responsibility to the Private Sector or to the States

If opportunities to control federal costs of LTC via new and more effective methods of cost containment are limited, then other avenues for controlling federal costs might be considered. Proposals that would extend greater financial protection against LTC costs do not necessarily imply that the relative role of the federal government would expand, although the absolute level of federal expenditures would probably rise. The following alternatives for the federal government are among those under discussion.

Maintain the Current Federal Share. The federal government might pay the same proportion as at present of additional costs that would result if states were required to increase subsidies for LTC or loosen eligibility criteria. Mandating an expansion in coverage and eligibility requirements while maintaining the current federal share of Medicaid costs would increase both federal and state Medicaid expenditures. State Medicaid programs, however, would continue to have substantial incentives to manage the expanded programs efficiently and to ensure that only eligible individuals would receive subsidies, thus limiting the growth in federal costs as well.

Private-Sector Alternatives. The federal government could encourage individuals and families to plan for their LTC needs either by purchasing insurance for LTC or by increasing their saving. Each of these private-sector options assumes that the federal government would continue to provide support through Medicaid or another mechanism for those individuals who are poor and without LTC insurance.

Although these alternatives would require substantial private-sector involvement in LTC financing, under most scenarios they also would require indirect federal expenditures to rise. The principal mechanism for encouraging individuals and families to save or buy insurance for LTC would be for the federal government to offer tax incentives for these actions, which would reduce federal tax receipts. The revenue losses could be as great as or greater than the longer-run savings to the federal government when fewer persons qualify for Medicaid payments for LTC.

Block Grants to the States. An alternative approach to controlling federal costs would be to develop a federal block grant to states to be used for LTC expenses and to replace current federal expenditures for LTC. Although the federal government would set minimum standards for state programs as conditions of eligibility for block grant funds, the states could be permitted considerable flexibility to design and manage LTC programs that would meet their individual needs.

This approach could result in higher or lower federal costs, depending upon the initial level of funding provided for the block grants and any subsequent decisions made by the Congress on the rate of increase in the block grant funds. The advantages of this approach are that it would permit the federal government full control over its spending on LTC services and that it would permit states to develop creative and responsive systems for allocating LTC funds among the specific needs and populations requiring such services.

A block grant program for LTC, however, has potential disadvantages. It would reduce the federal government's control over the use of funds that it allocates for LTC services. In addition, states are already projecting that Medicaid costs will absorb approximately 22 percent of state budgets by fiscal year 1995. Pressures to reduce the federal budget deficit might result in the block grant's being funded initially below current projections of federal LTC costs. Similarly, each year decisions about increases in the funds provided through the block grant could be affected by concerns about the economy, the deficit, and competing needs.

If states received less money under a block grant than they would have received from the federal government for LTC under current law, then either the states would be forced to absorb these additional costs within their own budget or they would restrict eligibility, services covered, or provider reimbursement levels. Any of these changes would affect access to care for some individuals and might also affect the quality of publicly subsidized care. A federal block grant program with minimum standard requirements for states to receive the grant also would result in geographic variation in public support for LTC services, as at present.

ALTERNATIVE RESPONSES TO THESE ISSUES

Problems associated with the current arrangements for financing and delivering LTC services have led to a continuing debate about whether and, if so, how to restructure LTC policy. These problems include the large financial costs to individuals who need LTC services, the demands placed on families and friends providing informal support, barriers to selecting the preferred mix of residential and nonresidential forms of LTC, and variation in the quality and accessibility of services by geographic area and source of payment for services.

Various proposals have been developed to address these problems. They vary in the extent to which they would expand financial protection against LTC costs and in the population groups for which this financial protection would be provided. In addition, the proposals vary in how they would allocate financial responsibility for LTC and in their effects on federal costs.

Two major approaches to restructuring the LTC system have been proposed. Under the first approach, restructuring the current LTC system would address specific identified problems and would adopt solutions that could be implemented incrementally, depending upon priorities and the availability of funds. This incremental approach to restructuring, through relatively modest changes in the Medicaid system, is discussed in Chapter IV. This approach is consistent with two different views of the appropriate strategy for restructuring LTC financing. One view holds that the current federal/state division of funding responsibilities and the means-tested nature of the Medicaid program have been reasonably successful in ensuring access to care for everyone regardless of ability to pay, that federal LTC spending is already substantial given competing priorities and the existing budget deficit, and that no compelling reason exists to change the system in ways that would substantially increase the level of federal spending. The other view holds that, given budgetary pressures and information deficiencies, incremental changes to Medicaid are the most appropriate way to begin a more extensive restructuring of LTC policy.

The second approach, which is discussed in Chapter V, focuses on proposals for a more fundamental restructuring of LTC financing and delivery that have been widely discussed in the past few years. These proposals include moving to a primarily private LTC financing system that would rely more heavily than at present on private savings or LTC insurance with only a residual public program, capping federal

LTC expenditures by providing block grants to the states, and developing a social insurance program under federal auspices that would provide individual entitlements. Clearly, these alternatives would extend very different levels of financial protection to those needing LTC services and would have widely differing potential impacts on federal costs.

Many of the issues that these options raise, and many of their advantages and disadvantages, have been discussed in Chapters I through III. Accordingly, Chapters IV and V consider only additional issues and arguments that are relevant to each approach.

CHAPTER IV

INCREMENTAL OPTIONS THAT WOULD RETAIN THE CURRENT DIVISION OF RESPONSIBILITY FOR LONG-TERM CARE

This chapter examines five changes to the Medicaid program that could be adopted individually or in combination and that would retain the same basic division of responsibility for the financing of long-term care as under current law. These illustrative options would retain Medicaid's present character as an income-tested and asset-tested program.

- Two of the options would address the suggested goals of LTC policy relating to the availability of services and financial protection against their costs by establishing medically needy programs in all states and by broadening the availability of H&CB services for severely dependent people.

- Two further options would help to contain net public outlays on LTC. One would tighten estate-recovery processes. The other would regulate growth in the number of nursing home beds and extend the requirement for preadmission screening to a wider group of nursing home applicants. Both approaches have been asserted to contain program costs but have not been proved to do so.

- The remaining option could make a modest contribution to enhancing quality of life for residents in nursing homes. It would raise and index the personal needs allowance, which enables Medicaid-eligible nursing home residents to make limited personal purchases.

MANDATE "MEDICALLY NEEDY" PROGRAMS FOR LONG-TERM CARE SERVICES

This option would address the position of people who are in a category covered by the state Medicaid program--for example, who are aged, blind, or disabled--but whose resources or incomes, though insufficient to pay their nursing home bills, nevertheless exceed the thresholds for categorical eligibility for Medicaid.

Background

Nearly all states use one of two mechanisms to assist at least some people in this situation--programs for "medically needy" people and special income limits for people in institutions.

For people who satisfy the categorical requirements for Medicaid eligibility, medically needy programs assist those whose resources and income, after payment of medical expenses, are within state-set resource and income standards. Once people have spent down to these standards, Medicaid will pay that part of the relevant Medicaid nursing home reimbursement rate not covered by the person's income. In July 1987, 33 states and the District of Columbia had medically needy programs that covered nursing home care.[1] For state outlays under these programs to attract full federal matching, a state's medically needy income standards may not exceed 133⅓ percent of the maximum Aid to Families with Dependent Children (AFDC) payment for a family of similar size. Thus, 1991 monthly income standards for an individual range from $100 to $776.

Alternatively, or in addition, a state may extend Medicaid eligibility to institutionalized people whose countable incomes, before deductions, do not exceed a special state-determined level. In 1987, 30 states used this mechanism; 17 of these states also had medically needy programs. The special income level is limited to three times the maximum Supplemental Security Income (SSI) benefit for individuals living in their own homes--a limit of $1,158 per month in 1990. Some states, however, set the level below the maximum level permitted. Whereas medically needy programs specify a ceiling on income after payment of medical expenses, this mechanism specifies a ceiling on income before payment of medical expenses, thus enabling states to place an absolute income ceiling on Medicaid eligibility. States can then deny eligibility to people whose incomes are higher but whose large nursing home bills might qualify them as medically needy. Some states use both mechanisms because, for people who qualify under both mechanisms, the special income level is administratively simpler.

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[1] Information in this paragraph and the next is drawn mainly from Congressional Research Service, *Medicaid Source Book: Background Data and Analysis* (November 1988), pp. 66-74.

Description of Option

This option would require each state to establish within Medicaid a "medically needy" program that would cover LTC services, incorporate the same protection of income and resources for the maintenance needs of a spouse living in the community as under current Medicaid law, and set the income eligibility threshold (after deducting allowable medical and LTC expenses) no lower than a federally specified level. This level could be the relevant poverty line or, for nursing home residents, a threshold that is lower than this by some portion of the costs for accommodations and food that nursing home charges subsume but that residents in the community must pay separately.

Advantages and Disadvantages

Mandating a medically needy program for LTC would assist people in categorical groups covered by Medicaid who are individually ineligible either because their incomes before LTC costs exceed their state's special income limits for institutionalized people or because their incomes after LTC costs exceed their state's medically needy income standard. People in both these groups may currently fail to receive care unless family members or friends help to finance it or providers offer them care that is not fully compensated.[2] This option would therefore improve financial protection for potentially vulnerable people, except in states that reduced their income thresholds from currently higher levels to the federally specified floor. In addition, a federally specified floor for the income eligibility threshold within this program would establish more consistent criteria nationally about when to provide public financial assistance for needed LTC services. Some people would regard a more consistent approach to these decisions as fairer, particularly for people in states with medically needy programs but relatively low maximum AFDC payments or in states whose special income limits for institutionalized people are relatively low.

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[2] For examples in which this situation has been encountered, see General Accounting Office, *Nursing Homes: Admission Problems for Medicaid Recipients and Attempts to Solve Them* (September 1990), p. 19.

By making more people eligible for Medicaid, however, this option would increase total Medicaid costs. Beyond this effect, however, the option's impact and cost are unclear. Reliable information is not available either on the number of people denied assistance because current law contains no such provision or on what happens to them--whether their care is financed by extended families or by state and local general assistance programs; whether they get charity care, informal care, or low-quality boarding home care; or whether they get no care at all. Accordingly, it is also unclear what Medicaid dollars would substitute for under this option. Unless a medically needy program were mandated for all Medicaid services, the option could also be seen as unfair to those who need services other than LTC. In addition, some people contend that national uniformity is not a virtue in welfare programs, and that eligibility criteria and benefits should be allowed to vary among states to reflect differences in wage rates, prices, preferences, and values.

EXPAND THE AVAILABILITY OF HOME- AND COMMUNITY-BASED SERVICES FOR SEVERELY DEPENDENT PEOPLE

Long-term care involves both medical and nonmedical services. The Medicaid program, however, was originally designed as a health care program. Thus, before 1981, Medicaid generally provided only medical and medically related services to frail elderly people living in the community, although the scope of the services it may provide to this group has broadened since then. Similarly, Medicaid limits its financing of residential LTC to nursing facilities.[3] Consequently, people needing nonmedical LTC services who live in certain areas may not be protected financially by the Medicaid program.

Background

States are permitted to provide a range of H&CB services as optional services under their state Medicaid plans but, if they do, they must offer them in all areas of the state and to all people eligible for Medicaid who require them. Under exemptions from normal Medicaid rules that are known as waivers, states may be authorized to restrict the availability of H&CB services to certain areas of the state and to defined subgroups of the Medicaid-eligible population. States wishing to make H&CB services available selectively use three main categories of waivers.

Section 1915(c) waivers permit states to provide H&CB services, in a budget-neutral way, for individuals who would otherwise have required care in a nursing facility. These waivers were first authorized by the Omnibus Budget Reconciliation Act of 1981 and were originally known as Section 2176 waivers. In 1987, 37 states operated such waiver programs for aged people and additional states did so for nonaged groups. There has been criticism, however, of administrative requirements associated with these waivers, including the test used to demonstrate budget neutrality. This test, critics claim, has the effect of penalizing states that have constrained growth in the number of nursing home beds.

Section 1915(d) waivers permit Medicaid to fund, in part or all of a state, a range of H&CB services for people aged 65 or older who have written care plans and who would otherwise be institutionalized. These services may also be provided to people who live in residential care settings less restrictive than a nursing home, such as a personal care home. The Omnibus Budget Reconciliation Act of 1987 established this waiver authority, partly in response to the criticism of

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[3] An exception is that Medicaid, under some programs authorized under waivers from normal Medicaid rules, will pay for H&CB services (not including room and board) that are provided to people in residential care facilities less restrictive than a nursing facility.

Section 1915(c) waivers. For a state electing this waiver, however, the annual growth in total Medicaid spending on nursing facility services and H&CB services for aged people must be limited under a formula to 9 percent or, if greater, to the sum of two growth rates: the projected rate of growth in the state's aged population; and a weighted average of the projected rates of growth in costs, per unit of service, for nursing facility services, home health services, and H&CB services. To date, Oregon is the only state to have elected the Section 1915(d) waiver option.

The Omnibus Budget Reconciliation Act of 1990, in what have become known as "frail elderly provisions" (or Section 4711 provisions), established "home and community care for functionally disabled elderly individuals" as a new, optional service that states could cover under their Medicaid plans in all or part of the state without demonstrating budget neutrality. States could define a class of individuals who satisfied the quite restrictive disability standards specified under the provisions and could target services to this group. The permitted services include homemaker/home health aide services, chore services, personal care services, nursing care services provided by (or under the supervision of) a registered nurse, respite care, adult day health services, certain services for individuals with chronic mental illness, and other approved services (not including room and board). These services could be provided in settings that included defined residential and nonresidential settings. States electing this option in any year, however, would be required for the whole year to provide such services to all individuals eligible for them. Annual federal spending on the provision would be capped at amounts rising from $40 million in fiscal year 1991 and $70 million in 1992 to $180 million in 1995. (Costs associated with assessment and case-management activities that are legislatively required when implementing the option could be eligible for federal matching separately as administrative costs.) States have not yet had to declare whether they will elect this option, but state officials have informally expressed reservations about a number of its aspects.

Most states currently seem to prefer using Section 1915(c) waivers rather than either Section 1915(d) waivers or the new frail elderly provisions. Because the average age of the aged population is rising, most states can anticipate faster growth in the number of nursing home beds than in their aged population. Consequently, the ceiling on annual growth in expenditures for all LTC services under Section 1915(d) waivers, which is pegged to growth in the aged population plus growth in costs per unit of service (or 9 percent, if greater), might not permit growth--or even maintenance--in the scale of H&CB services that a state can provide under Medicaid. Although the incentive for states to participate in the frail elderly provisions will grow until fiscal year 1995 as the maximum available funding increases, states reportedly also see the following disincentives to electing this optional service:

- Once states have defined the class of people eligible for this service, their financial commitment is open-ended for that year, and they cannot limit the number of clients served in a manner commensurate with the limit on federal Medicaid funding for the service.

- Although the service can be provided in defined residential or nonresidential settings for small or large groups, these settings are required to meet specified licensing or safety standards. For large residential and nonresidential settings, the licensing standards would be similar to those for nursing facilities and may be considerably more stringent than those currently in force under state law. No provision exists for arrangements that would permit a transition to the new standards.

- States would be required to establish and implement an annual certification process that meets specified criteria and is based on periodic review for all providers of community care funded under the frail elderly provisions.

- The mechanism for allocating available federal funds among states is imprecise if some states do not elect the option. If additional states elected to participate over time, not only the share but also the absolute level of funds available to a particular state could conceivably fall from one year to the next.

Description of Options

These options would facilitate expanded access under Medicaid to H&CB services for people living in the community or in residential care settings less restrictive than a nursing home, such as personal care facilities. This expanded access could be achieved in one or more of the following ways:

- The maximum permitted growth rate in total LTC service costs under the Section 1915(d) waiver authority could be modified to include an additional factor. This factor would reflect the proportional effect on the state's projected nursing home population of shifts in the composition of the state's aged population toward age groups that make greater use of nursing facilities. Including this factor would give states electing the waiver greater flexibility.

- The Section 1915(d) waiver authority and the frail elderly provisions could be extended to all younger adults with disabilities who are otherwise eligible for Medicaid.

- States electing to provide the optional service authorized by the frail elderly provisions could be permitted to negotiate limits with federal authorities on the average number of clients they would be required to serve under the provisions over the course of the year. If this change induced more states to provide this service, its effect in practice would be to expand access to H&CB services.

- States that provide services under the frail elderly provisions could be permitted to negotiate, with federal authorities, transitional arrangements for licensing standards for large residential and nonresidential community care settings covered under the provisions.

- The Congress could mandate that states make available through Medicaid H&CB services equivalent to those that are currently optional under the frail elderly provisions and that states target these services toward a similar group. The

> Congress could also mandate that states additionally observe a prescribed limit on growth in total Medicaid outlays on LTC services. This limit could be the same as the limit under Section 1915(d) waivers, except that it could incorporate the change suggested in the first of these options above.

Advantages and Disadvantages

These options would increase access to H&CB services, which surveys show are typically preferred by older Americans who need LTC assistance. They could also facilitate financial protection against the costs of care in residential settings less restrictive than a nursing home. These changes would increase the extent to which individuals could choose among LTC services on the basis of care requirements rather than on the basis of differences in these services' financing arrangements--a focus of criticism of the current LTC system. The changes might thereby reduce premature admissions to nursing homes and, to the extent that they did so, might enhance quality of life for Medicaid beneficiaries able to take advantage of them. Moreover, linking these changes to limits on permitted growth in Medicaid outlays for LTC would help to address the cost-containment concerns that have proved to be stumbling blocks for proposals to expand financial protection for H&CB care. Growth limits of this kind would also mesh easily with the option discussed below to regulate growth in the number of nursing home beds eligible for federal funding.

States might refuse to participate in a voluntary program, however, because available evidence suggests that attempts to substitute H&CB services for nursing home care usually do not reduce total LTC costs and may increase them. This result occurs largely because it is hard to identify, and to target H&CB services toward, people who would otherwise have been long-term users of nursing home care. Yet limiting growth in a category of Medicaid outlays for LTC, whether under the Section 1915(d) waiver authority or under this option, would require that administrative processes within Medicaid be able to identify and target this group and also be able to allocate a fixed budget among individuals with varying levels and kinds of need. States would probably object to mandatory aspects of the option because they would have to finance any additional costs that were generated. Moreover, some people might view caps on growth in expenditures as implying the loss of Medicaid's open-ended budgetary commitment--something that, however imperfect, they still consider to be the best guarantee of access to health care and LTC for poor or medically needy people.

TIGHTEN ESTATE-RECOVERY PROCESSES AND RULES

Another change in Medicaid that would help to contain its LTC costs would be to adopt the recommendations of the Inspector General of the Department of Health and Human Services for tightening estate-recovery processes.[4] These recommendations are outlined below.

Background

Medicaid's asset-test provisions are meant to ensure that people who need formal LTC use their own resources to purchase this care before qualifying for Medicaid assistance. Subject to certain restrictions, states have the authority, and sometimes the obligation, to restrict transfers of assets for purposes of obtaining Medicaid eligibility; to place liens (a legal right to hold property or have it sold or used for payment of a claim) on the real property of Medicaid recipients to ensure the property's availability for later recovery; and to recover the costs of care from the estates of deceased recipients.

Transfers of Assets. To limit the circumstances in which people can transfer their assets to others once they need or expect to need LTC, a new national policy on the transfer of assets governs the eligibility for Medicaid of people who applied after June 30, 1988, and who transferred assets after this date. Under this policy, institutionalized individuals who are otherwise eligible for Medicaid but who have disposed of resources for less than fair market value within the previous 30 months are ineligible for Medicaid-financed nursing home care for the number of months during which the uncompensated value of the transferred assets would have covered the average cost of private nursing home care (or for 30 months, if less).

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[4] Department of Health and Human Services, Office of Inspector General, *Medicaid Estate Recoveries* (June 1988).

The prohibition on transferring assets does not apply in defined circumstances, including the transfer of the applicant's home to his or her spouse, child under 21, blind or disabled adult child, or (in certain circumstances) sibling; transfer of other resources to the individual's community spouse or blind or disabled child; and transfers for a purpose other than to qualify for Medicaid. People may also legally retain sufficient private assets to pay for up to 30 months of nursing home care, transfer the balance of their assets to others, and qualify for Medicaid-financed nursing home care 30 months later. The 1988 policy allowed financial assets to be converted to real or personal property, to be transferred legally from the applicant to the community spouse, and then to be transferred again to an adult child or other third party. The Omnibus Budget Reconciliation Act of 1989, however, contained provisions designed to prevent people from transferring exempt real or personal property to the community spouse and then to others.

Liens and Recoveries from Beneficiaries' Estates. In specified circumstances, Medicaid law permits states to place a lien on the property of an institutionalized Medicaid beneficiary before death to secure recovery of the cost of Medicaid claims paid on his or her behalf. Two limits on the circumstances in which states may place liens are that the state must first determine with due process that the beneficiary "cannot reasonably be expected to be discharged from the medical institution and to return home." Second, the state may not place a lien if the beneficiary's spouse, a minor or dependent child, or a sibling with an equity interest and residency exceeding one year lawfully resides in the home. In addition, any such lien dissolves if the person is discharged from the medical institution and returns home.

The Inspector General reported in 1988 that only two states used the authority available to place liens before death to secure property for the recovery of benefits. He suggested, as major reasons for states' failure to use liens, that most real property of Medicaid beneficiaries already counted toward eligibility limits, had been transferred legally beyond the reach of liens, or else was exempt from liens because the beneficiary's home was occupied by qualifying relatives or because the beneficiary was not permanently institutionalized.

The Inspector General reported that 23 states and the District of Columbia recover benefits from the estates of deceased Medicaid recipients but that together they recovered less than $42 million annually. He estimated, however, that if every state recovered at the same level of effectiveness as the most effective state, which he considered to be Oregon, recovery nationwide under then-current law would have been $589 million. (He considered that this amount could be much greater, however, if his recommendations were adopted.)

Instead of liens, Oregon uses alternative measures on behalf of the recipient and the state to retain property in the name of the recipient, from whose estate it may be legally recovered to reimburse LTC costs. Oregon aggressively identifies assets, has conservators appointed to protect the property rights of recipients, files suits to reverse illegal transfers, relitigates abusive divorce decrees, partitions undivided property, and invades trusts.

Description of Option

The Inspector General recommended that action be taken to change Medicaid rules to permit families to retain and manage property while their elders receive LTC; to strengthen the transfer-of-asset rules so that people cannot give away property to qualify for Medicaid; to require, as a condition of Medicaid eligibility, a legal instrument to secure property owned by applicants and recipients for later recovery; and to increase estate recoveries as a nontax revenue source for the Medicaid program while protecting the personal and property rights of recipients and their families.

Advantages and Disadvantages

Adopting the Inspector General's recommendations to tighten estate-recovery processes and rules would have three advantages. First, it would result in more widespread use of people's privately available resources to defray their Medicaid costs. Advocates of a welfare approach to public LTC financing would see this as promoting greater fairness by achieving more consistent implementation of asset testing. Second, in the process, Medicaid estate recoveries might lessen the overall use of taxpayers' funds to the extent that Medicaid payments for LTC services could be recovered from the estates of beneficiaries. Third, programs of the kind operating in Oregon could enable relatives who might otherwise have sold a beneficiary's home to pay LTC costs to purchase this care instead at Medicaid rates while retaining use of the house until their own deaths.

For those who believe that public LTC financing should keep income and asset levels roughly stable as a person's health status deteriorates, adopting the Inspector General's recommendations would have the disadvantage of making means-testing more stringent instead of making the present system less dependent on means-testing. In the process, it would heighten the inconsistency between the eligibility requirements for publicly subsidized care for acute conditions and those for publicly subsidized care for chronic or long-term conditions.

MANDATE STATE REGULATION OF GROWTH IN THE NUMBER OF NURSING HOME BEDS AND PREADMISSION SCREENING FOR ADDITIONAL NURSING HOME APPLICANTS

This option might reduce Medicaid nursing home outlays, although the net effect on total Medicaid costs would be uncertain. It could also be one component of a strategy to alter the balance between nursing home care and other forms of LTC.

Background

Nursing home care absorbed 77 percent of total LTC spending and 90 percent of Medicaid LTC spending in fiscal year 1988. The supply of nursing home beds varies widely across the country, however. According to a 1987 report, these variations can be only partly explained by higher need levels caused by differences among states in the relative size of the oldest cohort.[5] The rate at which available beds are used also varies, although there is no correlation between the number of beds per 1,000 population and the occupancy rate.

Although the costs of acute health care and formal H&CB care mean that roughly one-third of people entering a nursing home already qualify for Medicaid when they begin their stay, another 7 percent are in nursing homes when, through spend-down, they become eligible for Medicaid. Moreover, those who are (or become) eligible have longer stays, on average, than others (see Chapter I). Medicaid programs for preadmission screening in a number of states already cover people being admitted as private patients who are expected to become eligible in the near future.[6] For example, several states cover people expected to become eligible within periods of 180 days or less.

Description of Option

This option would mandate that states regulate growth in the number of nursing home beds eligible for federal funding through Medicaid, Medicare, or other programs by requiring that providers wishing to operate additional beds in new or enlarged nursing homes must first obtain a certificate of need. The criteria for issuing a certificate of need would incorporate new guidelines for controlling growth that related the need for additional nursing home beds in a specified area to the number of beds already available in that area relative to the estimated population at risk for nursing home care. The guidelines would be set by the state, subject to federal approval. The guidelines, for example, might permit new beds only if the number of existing beds represents less than a specified proportion--such as 5 percent--of the aged population. Alternatively, more sophisticated guidelines might also reflect the age distribution of the population aged 65 and over by giving progressively greater weight to older cohorts, might include an explicit factor for younger adults with disabilities, or might allow for interregional migration patterns that are associated with the need for LTC.

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[5] See Department of Health and Human Services, *Report to Congress and the Secretary by the Task Force on Long-Term Health Care Policies* (September 1987), Appendix B16, p. 253.

[6] See Congressional Research Service, *Medicaid Source Book*, pp. 111-112.

The option would also mandate that preadmission screening be extended to all people admitted to nursing homes that are eligible for any federal funding (including Medicare and funding from the Department of Veterans Affairs), instead of being limited to people who either are eligible for Medicaid-reimbursed care when they are admitted or else are expected to become so shortly thereafter.

Advantages and Disadvantages

In areas whose supply of nursing home beds is high relative to average national patterns, guidelines for controlling growth could help to curb further increases in Medicaid outlays for nursing home care. At the same time, by regulating the number of beds, the guidelines would help to make nursing home outlays more predictable for state budget planners. Moreover, if such guidelines accompanied the earlier option that would expand alternatives to nursing home care under Medicaid, they could serve as a tool for hastening change in the balance among LTC services. In addition, extending preadmission screening programs might help to reduce premature admissions to nursing homes and to redirect the individuals concerned to more appropriate care. Insofar as it did so, it would delay for some individuals the time when they became eligible for Medicaid-financed nursing home care and thus would reduce Medicaid outlays for these individuals.

Growth-control guidelines, however, might shift Medicaid nursing home costs to the hospital sector, if nursing home beds were unavailable for Medicaid-eligible hospital patients, or to the H&CB care sector, in states where Medicaid paid for H&CB care.[7] Moreover, by sheltering existing providers against competition from new entrants, certificate-of-need processes could increase rates of return for existing providers and reduce their incentives to be efficient and to provide care of high quality.

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[7] See General Accounting Office, *Nursing Homes: Admission Problems for Medicaid Recipients and Attempts to Solve Them* (September 1990). The report suggests that extended delays occur in some states in discharging Medicaid hospital patients to Medicaid-financed nursing home beds. These delays may occur either while applications to establish Medicaid eligibility are being processed or while nursing homes that are willing to admit particular Medicaid-eligible residents are being found. The report implies that delays for the former reason affect Medicaid clients and those expected to become eligible for Medicaid shortly but do not affect other hospital patients who are expected to pay privately for their nursing home care.

Furthermore, some people might view growth-control guidelines as program caps implying the loss of Medicaid's open-ended budgetary commitment and hence the weakening of Medicaid's assurance of health care access for poor or medically needy people. In addition, if growth controls became a major element of Medicaid's cost-containment strategy during an era in which the population is aging, they could easily result in denial of needed care. Finally, extending preadmission screening would deny some people the right to make autonomous decisions to enter a nursing home, even though they might have the resources to pay privately for all of this care. Alternatively, it might have no impact on decisions about nursing home admissions, in which case it would prove ineffective as a cost-containment mechanism.

RAISE AND INDEX THE PERSONAL NEEDS ALLOWANCE

The options discussed in this chapter give least emphasis to the goal relating to quality, partly because it is not yet known how the provisions of the 1987 reconciliation act that restructure the regulation of nursing homes will affect quality. This option might have an appreciable effect on the quality of life experienced by nursing home residents. It would change the level of monthly income that Medicaid allows nursing home residents to retain for their personal use, which affects their ability to control discretionary consumption. The level of income retained is a by-product of the specific way in which Medicaid spend-down provisions balance the goals of containing costs and providing financial protection.

Background and Description of Option

A Medicaid-eligible resident whose income and nonexempt assets have already been used to help pay for his or her nursing home care may be liable for a range of expenses--such as clothing, toiletries, and reading material--that Medicaid does not cover. To provide for such expenses, residents who are recipients of Supplemental Security Income receive a personal needs allowance. Other Medicaid-eligible residents are allowed to retain an equivalent amount of their own income. The level of the allowance was first set in 1972 at $25 per month and has been raised once since, to $30 per month by the 1987 reconciliation act. This option would raise the level of the allowance further and index its value for future years. Achieving the same purchasing power in 1990 as in 1972, for example, would require an allowance of $67.30 per month.

Advantages and Disadvantages

Nursing home residents already experience greatly reduced personal autonomy because of the nature of their dependencies and the restrictive character of life in a nursing home. Raising the personal needs allowance and safeguarding its purchasing power from erosion by inflation would increase the ability of Medicaid-eligible residents to make small purchases to meet daily needs. In this way, it could enhance their quality of life. The option, however, would raise Medicaid costs. Further, it would not achieve its intended effect if nursing home operators were able simply to expand the range of items that residents were left to purchase.

CHAPTER V

OPTIONS THAT WOULD SUBSTANTIALLY MODIFY THE DIVISION OF RESPONSIBILITY FOR FINANCING LONG-TERM CARE

A number of strategies would substantially modify the present division of responsibility for long-term care. One strategy would make greater use of the private sector--in providing funds to pay for services supplied by private organizations--but it would not necessarily reduce taxpayers' costs for LTC and could well increase them. Another strategy would assign greater responsibility to state and local taxpayers than does current law, and a third would expand the financial responsibility of federal taxpayers.

STRATEGY ONE: SUBSIDIZE PARTICIPATION IN PRIVATE ARRANGEMENTS THAT FINANCE LONG-TERM CARE

Fiscal critics of the present system generally advocate an expanded role for the private sector in financing LTC services. One way to accomplish this might be for the public sector to withdraw all or part of its current funding for LTC services and to allow individuals or organizations within the private sector to substitute alternative LTC financing arrangements.

Proposals for federal policy to assign the private sector an expanded role typically call for active government assistance or encouragement in establishing the private financing arrangements concerned. Some proposals favor assistance in the form of regulatory action to clarify the rules under which private individuals and organizations would operate. Many proposals also call for financial incentives, such as tax preferences, to encourage participation in the private financing arrangements. Advocates offer two rationales for supporting the strategy:

- They assert that the direct reduction in revenue resulting from the tax preferences would be more than offset by consequent reductions in government spending. Although this approach may have considerable potential to reduce direct public funding for LTC in the long run, the indirect costs to government of any tax preferences or other financial incentives that are provided must be included in the full public costs of this approach.

- They present such proposals as an attractive compromise between a welfare approach to LTC that does too little to promote financial protection and a comprehensive social insurance approach that does too little to limit the public sector's share of LTC financing.

This section examines three approaches that illustrate this strategy. The first two involve forms of private LTC insurance and the third involves forms of private saving. The first and third of these approaches, as well as variants of the second, would grant public subsidies for participation in private LTC financing arrangements. Like most proposals that follow this strategy, all three approaches would retain Medicaid as a residual welfare program to assist poor people and, under a variant of one approach, certain other groups. The size of the Medicaid program would remain substantial, particularly in the short run.

Provide Tax Subsidies for Private LTC Insurance Expenditures

To provide financial protection against the costs of LTC, the government could structure tax subsidies for private expenditures on LTC insurance in several ways.

Description of the Options. This group of options would provide a refundable income tax credit for expenditures on qualifying individual or group LTC insurance policies or risk-pooling arrangements. To qualify, policies would need to meet minimum standards on such issues as the scope of coverage, renewability, vesting, and inflation protection. Policies could be "medically underwritten," however, so that coverage could be denied to people who, when they applied for it, already needed care or had conditions implying a probable future need for care. Qualifying insurance policies could either provide indemnity benefits or fund appropriate managed LTC. The policies would also offer a schedule of actuarially determined annual premiums that increased with the age at which the policyholder first participated in the risk pool.

Options embodying this approach could differ in the way they treat the relationship between the maximum value of the credit and an individual's income. One set of options would allow a uniform credit for all taxpayers. The other set would reduce the maximum allowable credit as income increased--for example, the maximum credit might equal the age-appropriate annual premium for those below the poverty line and, for others, it could be reduced by some fraction of income above this threshold.

The tax subsidy approach is potentially very flexible. For example, options could be structured so that, as income rises above some threshold, the net benefit is reduced by any desired proportion of the income remaining once other tax liabilities are met. Any break-even level of income desired for families of a particular size and composition could be achieved by choosing an appropriate threshold and benefit reduction rate. In addition, options could cover the entire population, including children and younger adults, or any categorical subset of it. Moreover, these program parameters could be the same for all states or they could differ among the states. In the latter case, standards could be either subject to federally mandated minimums or left to the discretion of state governments.

The distributional implications of these options would depend in practice on the characteristics of the people who participated--higher-income people and those without preexisting conditions would probably do so disproportionately--and on how the tax credits were financed. These varying implications can be illustrated, however, by applying different options to a hypothetical case: one in which everyone participated and in which the credits were financed by an increase in income tax rates for all taxpayers with a tax liability. (If some other revenue measures or expenditure reductions were used, the distributional implications would be less clear.) In this hypothetical case:

- Options that would allow a uniform credit for all taxpayers would have redistributional effects characteristic of a social insurance program. They would therefore also have the greatest budgetary cost.

- Options that would reduce the maximum allowable credit as income increased would be analogous to an in-kind negative income tax for LTC risk-pooling expenditures (just as the Food Stamp program is a form of negative income tax for food expenditures). These options would have redistributional effects characteristic of welfare programs and would have lower budgetary costs than corresponding options in the other set with the same maximum credit.

Advantages and Disadvantages. Providing tax subsidies for private LTC insurance expenditures would promote increased financial protection against the costs of LTC for people purchasing coverage, particularly for those with relatively fewer resources, by reducing the net cost of participating in private risk-pooling arrangements. Making the tax credit refundable would assist people with small or no tax liabilities who would not otherwise benefit fully from the credit. The credit might also be made available as a voucher that LTC insurers and providers of prepaid LTC could redeem so as not to penalize people with liquidity problems. This modification, however, would increase administrative complexity and costs. In all of these variations, the private-sector involvement and the delivery of public subsidies (other than those for the welfare program) in the form of tax expenditures rather than direct outlays would appeal to some people.

People who would prefer a LTC system that provides the same quality of care in a uniform way to all who need it might be attracted by another feature of the refundable income tax credit approach. The tax credit could be designed to achieve any desired structure of resource-related subsidies on the financing side of the LTC system. Consequently, the approach could eliminate the need for service providers to be involved in administering resource tests that establish different effective prices for different users and that can also affect the nature of the care received or the manner in which it is provided.

This approach, however, would not assist people who already need LTC services or who could reasonably be expected to need them. Risk-pooling arrangements that are actuarially fair could be expected to exclude people with preexisting conditions, to deny them coverage for care associated with those conditions, or to charge them premiums equal to the expected cost of care. Thus, the option could directly assist only those people who in the future developed a need for LTC for reasons that are not currently predictable.

Among people who are able to buy LTC insurance, sales of LTC insurance have grown in recent years and seem likely to continue growing as policies improve, sales efforts grow, and incomes rise. For people who would buy policies anyway, subsidies would provide windfall gains at taxpayers' expense. Yet the long-term commercial viability and the large-scale consumer appeal of private LTC insurance remain to be demonstrated. Consequently, it is not clear what level of subsidies (and hence what level of public-sector costs) would be required to achieve substantial LTC insurance coverage among the population, but this level of public-sector costs might well exceed any savings to the Medicaid program. In addition, marketing and administration might easily absorb 40 percent of private LTC insurance premiums, so that high premiums could discourage even many risk-averse people from purchasing such insurance.[1] Moreover, people with modest means might not choose to purchase such insurance, but most would have to contribute to financing the tax subsidies for it. A further disadvantage is that increased participation in LTC risk pooling would reduce the incentives for LTC consumers to use only necessary services and so might tend unduly to increase total LTC costs.

Finally, some people would object to the tax credit mechanism itself. Means-tested credits raise the effective tax rate on the income of taxpayers in the phase-out range. A LTC credit, therefore, might discourage work effort, especially among low-income workers and married couples with two earners. Its effects would add to those of other existing phased credits such as the earned income tax credit and the child-care credit, Social Security payroll taxes, and possibly also higher income tax rates if they were used to offset the revenue forgone because of the LTC tax credit.

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[1] Marketing and administration typically absorb a significant proportion of private health insurance premiums. The standard for private LTC insurance policies recommended by the National Association of Insurance Commissioners would require 60 percent of premiums to be spent on LTC benefits.

Mandate Community-Rated, Employer-Sponsored, Group LTC Insurance

Another way to expand the private sector's role in LTC financing would be to mandate that long-term care insurers make community-rated group LTC insurance policies available to employers, that employers offer group LTC insurance policies to employees, and that employees purchase them.

Background. By January 1991, about 80,000 people had purchased LTC insurance under employer-sponsored arrangements.[2] The policies varied considerably and were optional for the employee, who typically paid the full premium. Coverage was available to the employee and in many cases to the employee's spouse or parents, but eligibility for this coverage was usually medically underwritten.

Community-rated insurance contrasts with experience-rated insurance, which adjusts premiums to reflect the health status or the prior claims experience of the particular individual or group, and which is the predominant form of private health or LTC insurance offered in the United States. For policies sold to individuals, community-rated health insurance or LTC insurance is insurance under which an individual's premium is not affected by how his or her health status or prior claims experience compares with that of otherwise similar individuals. For policies sold on a group basis, community-rated health or LTC insurance is insurance under which the premium for any particular group is not affected by how its average health status or prior claims experience compares with that of otherwise similar groups. Rather, premiums for community-rated insurance policies are based on the expected average claims and administrative costs for the population as a whole or for designated classes of individuals or groups within the population who are covered by the policies--for example, all people in a given age group.

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[2] S. Van Gelder and D. Johnson, "Long-Term Care Insurance: A Market Update," *Health Insurance Association of America Research Bulletin* (January 1991).

Description of Option. This option would establish a system of community-rated, employer-sponsored, group LTC insurance with a standard package of benefits. An option of this kind could be implemented and operated in a variety of ways. The description here includes illustrative details of one way in which such an option might be structured. These details help to highlight aspects of the option that are not intuitively obvious.

Under the illustrative option, the mandate would initially cover all employees who work at least 25 hours per week and who are aged 50 or younger. It would also cover their immediate family members aged 50 or younger. Coverage would be mandatory for eligible employees and their families. Over time, coverage of the population would become increasingly complete as this cohort of covered individuals grew older and as newly eligible people aged 50 or younger acquired coverage for the first time. Premiums would vary with the ages at which people first obtained coverage.

The option has three variants:

- Under one variant, employees would pay the relevant premiums from after-tax income and the government would not directly subsidize premium payments.
- Under another variant, employees' premium payments, although still paid from after-tax income, could qualify for a refundable income tax credit similar to the one described in the previous option.
- Under a third variant, employers might pay all or part of the premium cost. The employer contributions would be taxable as income to the employee when the contributions were made. Employees would receive tax benefits, however, in two ways: the insurer's earnings on accumulating reserves would be exempt from income tax; and any insurance benefits paid to people covered under the policy would be simi-

> larly exempt. Although this tax treatment is structured differently from that for pension plans, it would confer a level of tax preference that, over the life of the employee, would be substantially comparable with the level granted to employer contributions to pension plans, as discussed in relation to the next option. Differences in the level of tax preference under the two treatments would relate to differences between the marginal tax rates that individuals faced as employees and as retirees.

The implications of this option may best be understood by considering further details of how such an option might function. These details relate to the roles of the principal participants involved and to the characteristics of the insurance policies themselves.

Role of the Federal Government. The federal government's role under this option would have several elements. It would establish the basic statutory and regulatory framework within which participating employers and insurance companies would operate a system of community-rated, employer-sponsored, group LTC insurance. Modifications--for example, in the standard benefit package--could be made over time for newly covered individuals as experience with the option accrued. As a supplement to the regulatory framework, the federal government would also establish a fund into which a small proportion of all LTC insurance premiums would be paid. The fund would provide those insured with a degree of protection against bankruptcies among insurers. Insurers would also be required to have adequate capital.

In addition, the federal government would sponsor clearinghouse arrangements to make maintaining coverage easier for people who change employers or leave the workforce and for their family members. The federal government would also be responsible for appointing an independent panel with actuarial expertise whose overall role--discussed further below--would be to preserve the actuarial integrity of the LTC insurance system, to maintain its fairness for all parties, and to oversee arrangements designed to address the technical challenges of such a system.

Role of Insurers and Characteristics of Policies. Insurance companies offering any LTC insurance policies would be required to offer a group LTC insurance policy having numerous characteristics. For example, the policy would be available to any U.S. employer that applied for coverage and that continued to pay the specified premiums. Thus, no employer could be excluded from coverage.

The policy would cover all employees working at least 25 hours per week, their spouses, and their dependent children. Because premiums would be structured so that premium payments would cease after age 65, coverage would be limited to individuals who were aged 50 years or younger when first covered. For most people, this would provide a period of up to 15 years during which their premiums could be used to prefund their expected benefits.

The policy would offer a defined package of cash benefits, as specified by the federal government, to eligible individuals of any age. Benefits would be adjusted annually by the percentage change in an index of LTC service prices. The benefits could include separate specified daily rates for nursing home care and for home and community-based services for people assessed as needing such care. Different rates of benefits could also be specified for people with different assessed levels of functional dependence. Supplementary coverage could be sponsored at the employer's option.

The insurance company would publish each year a single schedule specifying the premium for any individual acquiring coverage for the first time in that year. This premium would depend only on the age at which the individual was first covered by such a policy; premiums would increase with age of first coverage. The total premium for an employee and any covered family members would be the sum of the relevant premiums for the individuals in the family. Premiums paid on behalf of each individual covered would be fully and immediately vested in an account for that individual.

The insurance company would be at risk financially for the policy. Nevertheless, premiums for each covered individual could be increased in certain circumstances. As discussed below, the size and permissibility of any such increase would be determined by the independent panel with actuarial experience.

Role of Employers. Employers would be required to deduct from each employee's gross income relevant premiums for the employee and any covered family members. Exceptions would be permitted for individuals over 50 who had not established coverage, employees who worked less than 25 hours per week, and employees who could demonstrate that they and their family members were covered under another family member's policy.

Role of the Independent Panel. The independent panel with actuarial expertise would have several responsibilities. First, it would establish the index of LTC service prices used each year to determine the proportion by which benefits under existing policies would be increased. The panel also would authorize insurers to adjust premiums for existing policies by specified amounts in certain circumstances. Because benefit rates would be adjusted annually, insurers would be unable to determine in advance precisely what premiums for new policies would be required to prefund fully their expected liabilities. Accordingly, the panel of actuaries would specify an expected annual rate of increase in benefit levels that insurers would be obliged to prefund out of the premiums specified for any new contract. The panel would then determine each year the extent to which actual growth in LTC service prices had differed from the expected levels assumed under policies issued in each year. On this basis, it would calculate the changes that would be required in premiums for people insured under existing policies, by year and age of first coverage, to enable insurers to prefund fully the changes in expected liabilities resulting from differences between actual and expected changes in LTC service prices. The panel could also be given authority to take into account the impact on insurers' expected liabilities of any court judgments affecting the interpretation of insurance contracts.

In addition, the panel would develop and oversee the technical aspects of clearinghouse arrangements under which employees who change jobs or leave the workforce, and their families, could transfer coverage to a new fund or preserve their vested benefit entitlements. Employees would have three options when leaving an employer. First, they could retain coverage with the same insurance company but would remit the full premiums themselves directly to that company. Second, they could transfer their coverage to the group policy of their next employer. The first employer's insurance company would then transfer to the second employer's insurance company the balance of the vested account through the newly established clearinghouse arrangements. Third, those no longer employed at least 25 hours per week could cease paying premiums but retain the right to partial benefits. Thus, the covered individuals' entitlement to benefits could be preserved, with the subsequent benefits being a proportional share of the benefits normally payable under the policy. The proportion could be the accumulated value of the premiums actually paid expressed as a fraction of the accumulated value of the premiums that would have been paid if premiums had continued to be paid until retirement.

Advantages and Disadvantages. Mandating community-rated, employer-sponsored, group LTC insurance could progressively establish widespread insurance coverage among the population, beginning with those aged 50 or younger and expanding as this cohort grew older. Of all people aged 50 or younger, 83 percent live in a family in which someone is employed at least 25 hours per week. Another 9 percent live in a family in which someone is unemployed or works less than 25 hours per week--all people who might expect at some time to hold jobs entitling them to LTC insurance coverage under the option.[3] If the unsubsidized variant of the option were adopted, the cost to taxpayers would be minimal. Otherwise, the cost to taxpayers would depend on the level and structure of the refundable tax credit for private expenditures on LTC insurance or on the scale of employer contributions.

Under the option, no one could be denied coverage because of preexisting conditions--a major drawback of existing LTC insurance policies as a vehicle for establishing LTC risk-pooling arrangements that cover the whole population. Similarly, large and small employers alike would have access to the same coverage arrangements. The level of financial protection against the costs of LTC would be high, partly because benefits would be indexed to the price of LTC services. Benefits provided under the policies would be prefunded and contractually defined, and private insurance companies would have strong financial incentives to prevent abuse of the benefits. Accordingly, cost containment would be less of a concern for policymakers (unless the federal government were to guarantee the bankruptcy fund).

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[3] Congressional Budget Office calculations based on March 1990 Current Population Survey.

The option, however, would achieve this coverage by compulsion. It would force LTC insurers to offer such coverage, employers to sponsor and possibly pay for it, and employees (except those who are exempt) to purchase it. Insurers would face considerable financial risks by offering, to most of the population, community-rated LTC insurance with substantial inflation protection that is tied to an unpredictable index; insurers might, in fact, choose to withdraw from the LTC insurance field rather than offer such policies. Also, the federal government might in practice become the reinsurer of last resort, assuming ultimate financial liability if the insurance arrangements collapsed because premiums were set too low and a significant number of the insurance companies involved went bankrupt.

Employers would have an additional administrative burden under this option. They would incur significant additional costs for labor only if they chose to contribute to LTC premiums using funds that they would not otherwise have paid as labor costs, and, in the long run, they would probably shift these costs to employees by increasing wages and salaries more slowly than otherwise. Any additional labor costs borne by employers could create incentives for them to employ fewer people--resulting in fewer jobs than otherwise--and to reduce work schedules to below 25 hours per week. These incentives might particularly affect workers earning close to the minimum wage.

Employees would be required to purchase private LTC insurance that many of them would not purchase otherwise. For the independent panel with actuarial experience, establishing effective clearinghouse arrangements and determining permissible increases in premiums on existing policies would present complex technical challenges.

Under a scheme with nationally uniform rates of cash benefits, geographic variation in LTC costs would cause some people to receive more than the cost of care in their areas and others to receive less. If geographic variation in rates were incorporated into the scheme, however, vesting provisions would be more difficult to administer, geographic cost differentials might change over time, and people who moved from low-cost to high-cost areas could receive benefits that did not cover the local cost of needed care.

Encourage Private Saving for LTC

Yet another option that illustrates the first strategy of subsidizing participation in private LTC financing arrangements incorporates four ways to help people pay for LTC from their private resources. The general advantages and disadvantages of this approach were examined in Chapter III, which suggested that it is generally quite difficult to intervene effectively to reduce the public sector's total LTC costs by providing subsidies for LTC-related savings. This section therefore discusses only the factors relevant to assessing the option itself.

Background. Private savings remain an important source of funds for formal LTC costs. Almost 45 percent of all LTC expenditures in fiscal year 1988 were private out-of-pocket expenditures financed from savings and other personal sources.

Various proposals have been made for federal policy to encourage saving specifically for LTC. Although the option discussed here incorporates a different approach, two widely discussed proposals have involved reverse mortgages and individual medical accounts. Reverse mortgages are an unconventional way to finance LTC by converting home equity into an income stream that could finance LTC services, LTC insurance, or other expenses. By incorporating annuity features, reverse mortgages can provide an income stream without jeopardizing the homeowner's security of tenure. The Department of Housing and Urban Development (HUD) is conducting a mandated demonstration program to insure reverse mortgages for older homeowners.

The Department of the Treasury's recent analysis of proposals for an individual medical account suggested as an alternative that individual retirement accounts might be adjusted to reflect LTC needs.[4] Such a measure would, in effect, incorporate LTC insurance within IRAs as part of a broader pension and LTC package. The goal of the package would be to allow the private pension and retirement income system to provide income support payments that varied, in an actuarially fair way, with the level of an individual's LTC needs. The option presented here reflects that suggestion.

The option would apply either the current tax treatment of existing pension plans or another similar tax treatment to certain forms of LTC insurance. Pension plans currently receive preferential tax treatment in that employer contributions on behalf of an employee, and interest on those contributions, are not taxed until they are withdrawn from the pension plan.

An alternative tax treatment of pension plans would provide the same overall lifetime level of tax preference for an individual whose marginal tax rate remained constant over time. Under this alternative treatment, an employer's contribution would be included in the employee's taxable income in the year that the contribution was made, but neither the interest earned on those contributions nor the pension benefits received would be taxed. Although the alternative tax treatment would be less favorable than the current treatment for individuals whose marginal tax rates as retirees receiving pension benefits are below their marginal tax rates as employees, the two approaches would otherwise confer a substantially similar degree of tax preference.

Description of Option. This option would encourage the acquisition of more flexible contingent assets (assets that would become available to their owners in defined circumstances such as retirement or disablement). It would do so by changing the tax treatment of retirement income and insurance plans in four ways so that people could arrange combined insurance against their needs for retirement income, LTC, and income for survivors. Each of these ways would confer on the LTC component of the combined insurance a tax treatment that is substantially equivalent to that of pension funds. The first three components of the option incorporate the alternative tax treatment discussed above. A variant of this option would limit the tax preferences discussed below to forms of LTC insurance that cover only nursing home care.

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[4] Department of the Treasury, *Financing Health and Long-Term Care* (March 1990).

Tax Treatment of LTC Insurance. The option would explicitly grant this tax treatment to LTC insurance. People would pay insurance premiums from taxable income, and premiums paid by employers on a person's behalf would be deemed taxable income, as is the case under current law. In addition, all premium income and earnings of the insurer that are used to establish actuarially required reserves would be made nontaxable. Under current law, nontaxable additions to reserves are effectively limited to below this level.[5] Benefits received by the insured person would also be nontaxable.

Combining LTC Insurance and Annuities. The option would permit what amounts to a "LTC rider" within an IRA package by allowing LTC payments as an option under annuity policies provided by life insurance companies and under those IRAs for which employee contributions are not tax deductible. A specified proportion of the annual annuity premium would be allocated to fund higher benefit payments for those individuals who developed a need for LTC services. The basic annuity payments that a person received would be taxable income, as they are now, but any additional cash benefits received because of LTC needs would be excluded from taxable income.

Combining LTC Insurance and Life Insurance. The option would facilitate early use of death benefits from life insurance to finance LTC. Early or "accelerated" death benefit payments to insured individuals who can demonstrate a need for LTC services would be made nontaxable insofar as they were spent on LTC. Accelerated benefit payments of this kind would result in equivalent reductions in the death benefit payable.

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5. Under current law, insurers may not deduct the full amount that an insurer would accumulate under LTC insurance policies. For example, reserves set aside for the first two years of a policy's life are not deductible, nor are reserves to meet the expenses incurred in paying claims. Also, the deductible level of reserves must be established using specified mortality tables that understate the number of people surviving into the oldest age groups.

Combining LTC Insurance and Pensions. Consistent with the second change involving LTC insurance and annuities, the option would also modify the law to permit employee pension plans (and other tax-qualified retirement plans--IRAs for which contributions are tax deductible, and "section 401(k)" plans) to vary the level of pension payment with the assessed LTC needs of the beneficiary. In exchange for an actuarially reduced amount of basic benefits, the plans could make higher payments to people assessed as requiring assistance to help them finance the purchase of LTC services. Although the tax treatment proposed below for this component of the option would provide substantially the same degree of tax preference as the tax treatment in the three previous components, it would be structured differently. The reason is that employees initially pay no tax either on contributions to pension plans that employers make on their behalf or on income from which they themselves make deductible IRA contributions. Accordingly, when people began receiving pension benefits, both the pension benefits received in cash and the actuarial value of the person's LTC insurance benefits would be included in taxable income.[6] LTC benefits paid in cash, however, would not be included in taxable income.

Advantages and Disadvantages. Subsidizing participation in private LTC financing arrangements would have several advantages. First, it would integrate private saving for LTC with the broader system of private saving for retirement income support. In the process, it would restructure benefits in the integrated system so that they would more closely reflect the varied financial needs of retirees that depend on their health. People attached to the labor force, and their families, therefore would find it easier to prepare for the possible costs of LTC. Next, because the private system of retirement income delivers benefits in cash, covered individuals who needed LTC would have greater flexibility to purchase the kinds of LTC they preferred. Moreover, the option would permit more flexible forms and combinations of saving and insurance. Where risks are mutually exclusive--for example, the risks of simultaneously needing LTC and income for survivors--risk

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6. The amount included in taxable income would be the larger pension benefit receivable by an otherwise identical employee who declined the LTC insurance option. This amount could be calculated from the size of the actual benefit and that amount's share of the pension benefit receivable had the person declined the insurance option. This share would depend on the fraction of contributions to the pension fund or IRA that would be required to fund the person's LTC insurance benefit--something that could be specified in advance for each pension plan or IRA.

premiums for combined policies might be lower than the sum of risk premiums for separate policies with similar coverage. Finally, clarifying the tax status of LTC insurance might increase its appeal to providers and employers.

Limiting these tax preferences to forms of LTC insurance that cover only nursing home care would limit the resulting reduction in revenue. It would also reduce uncertainty about this cost by avoiding the need to estimate the increase in demand for H&CB services that would result from including more comprehensive forms of LTC insurance within the option. In addition, excluding H&CB care from the tax preferences would eliminate some complexities for administrators of pension plans and other retirement income programs.

The option also has several disadvantages. One is that administrators of pension plans and other retirement income programs would face the challenge of assessing individuals' needs for LTC, determining legal entitlements, and translating assessed disability levels into appropriate levels of cash payment. Given the potential for disagreement about assessed needs, it is not clear how this option would contain costs. The present LTC system relies primarily on consumer choice, government regulation, coinsurance, and federal/state sharing of costs under Medicaid as approaches to containing costs and assuring quality. This option would increase the emphasis on consumer choice but, by enabling people with LTC needs to purchase additional LTC from their augmented personal resources, it might raise LTC prices. It could also lead to cash payments for some--and perhaps much--informal care that is already being provided.

In addition, only limited data are available for determining the reduction in basic benefits that would be actuarially fair. Moreover, given the potentially large cost of providing additional benefits commensurate with LTC costs to all who would be entitled to them under this system, some retirees not needing LTC might consider the actuarially reduced level of benefits inadequate to meet their retirement income needs. Furthermore, many individuals would not have access to this form of saving for LTC, would not be able to afford it, or would not choose to participate, whereas others would presumably have LTC costs that exceeded the system's LTC benefit limits. Also, there is no assurance that this option would represent a cost-effective use of taxpayers' funds in increasing financial protection against LTC costs. Indeed, the discussion in Chapter III concerning individual medical accounts suggests skepticism.

For some survivors of people requiring LTC, permitting early use of life insurance and pension entitlements to pay for these services might reduce the resources available to them later, although for others it might merely change the form of the assets they retain, allowing them to avoid selling real assets to meet the costs of care.

Limiting these tax preferences to forms of LTC insurance that cover only nursing home care would have the additional disadvantage of biasing choices from among types of LTC services. Critics of the present system contend that it already exhibits a bias away from both H&CB care and forms of residential LTC other than nursing homes, which would sometimes be more appropriate to the needs of those requiring care.

Retain a Residual Welfare Program

The strategy of subsidizing participation in private LTC financing arrangements would presumably retain Medicaid either in its present form or a revised one. For example, Medicaid might continue to cover people who could not afford to finance LTC from their own resources (including LTC insurance and savings).

Alternatively, if it were a premise of public policy that all people able to purchase LTC insurance should do so, Medicaid LTC coverage might be restricted under the illustrative refundable income tax credit options to just four groups of people: those denied LTC insurance coverage because of preexisting conditions in, for instance, the first two years after the credit was introduced; immigrants and newborns subsequently denied LTC insurance coverage owing to preexisting conditions; those who had exhausted the benefits of qualifying LTC insurance policies for which they had claimed the credit; and those with inadequate resources for coinsurance payments under these policies. Under this approach, Medicaid LTC liabilities would ultimately decline as a growing proportion of the group needing care acquired LTC insurance coverage. Anyone who did not try to arrange LTC coverage, however, would be left without protection against the costs of LTC. Moreover, if any companies providing qualifying LTC insurance coverage should fail, then, unless mandatory reinsurance schemes or other guarantees were in place, a question would arise as to whether Medicaid should finance any LTC for people those companies had insured.

STRATEGY TWO: ESTABLISH A BLOCK GRANT TO THE STATES FOR LONG-TERM CARE

The second strategy would define limits to federal financial and policy responsibilities for LTC by establishing block grants to the states. Because these grants could involve varying levels of federal financial and policy involvement, CBO examined two variants. One illustrates a comparatively minimal role for the federal government and could reflect a high federal priority for containing federal outlays for LTC. The other illustrates a substantially greater federal role in defining the structure of the LTC system for which states would be responsible and also assumes a correspondingly greater level of federal financial involvement.

Minimal Federal Role: Indexed Block Grant for LTC

An indexed block grant designed to minimize the federal role in LTC would maintain federal outlays for LTC at their present level in inflation-adjusted terms, and would make states almost solely responsible for LTC policy.

Description of Option. This option would consolidate current federal LTC funding through health, social service, and aging programs--including Medicaid, Medicare, and portions of the Older Americans Act funds and of the Social Services Block Grant--into a block grant that would be indexed annually for overall inflation and possibly also for the rate of growth in total population. States would then become responsible for policies concerning financial protection against the costs of LTC, cost containment, and quality. The principal condition of the grant would be that states show that they had spent the grant on LTC and had maintained their own spending in real terms. If federal policymakers wished to retain influence over the broad shape of states' LTC programs, additional conditions of the grant could specify minimal requirements relating to eligibility, quality standards, and the range of benefits to be covered.

Advantages and Disadvantages. The major advantages of this option are that it would impose a ceiling on federal outlays for LTC and would permit the limiting of real growth in federal costs (or possibly in federal costs per person). Given the projections of federal costs under current law, these characteristics are a striking feature of the option. Indeed, it is the only option discussed in Chapters IV and V--with the possible exception of mandated employer-sponsored, unsubsidized group LTC insurance--that would dramatically lower federal costs compared with current law. Moreover, in the process of limiting federal LTC outlays, this option would make them more predictable. It would also be consistent with the view that primary responsibility for LTC policy and for the design of LTC delivery systems should rest with the states--a view held, for example, by people who consider that states are better able to develop programs that are responsive to local conditions, attitudes, and complementary community services.

The major disadvantages are that this option would be likely to shift costs to the states just as the number of people requiring LTC is expected to balloon, compounding the pressure that expanded responsibility for acute health care costs has placed on state budgets in recent years. Even if the block grant were indexed for general inflation and overall population growth, it would not reflect either growth rates for input prices that exceed general inflation or the impetus toward increased LTC service use that the population's changing age structure induces. States, providers, and recipients would presumably object to capping an entitlement program so as to reduce the federal government's financial liability under the program. The option would also perpetuate existing disparities in states' efforts. In addition, it could result in a different system, with different standards and eligibility rules, in each state, thereby creating incentives for older people to move to states with more generous programs. Alternatively, this option might create disincentives to interstate migration following retirement if states established non-Medicaid programs for LTC that related individuals' benefits to the number of years they had contributed to the programs' financing.

Substantial Federal Role: Social Insurance via a Formula-Based Block Grant to States

An indexed block grant designed to maintain a substantial federal role in LTC could combine a formula-based federal block grant with funds for LTC allocated from state tax revenue to cover the costs of individuals' care. These funds would be allocated by a federally shaped but state-administered program like a social insurance program.

Description of Option. This option would replace current federal LTC funding--defined in the same way as for the previous option--with a formula-based block grant to the states. Under this formula, the federal payment would grow at a rate reflecting not only general inflation and overall population growth but also the impact on LTC use of the population's changing age structure--an important difference from the previous option. The formula, for example, could reflect the age structure within the state's population by incorporating progressively higher indexed capitation rates for successively older age cohorts within the state's population. It could also reflect the state's average per capita income. States would therefore receive a predictable, growing level of federal funding for LTC. States would be required to show that they had maintained their own spending per aged or disabled person in real terms.

Three variants of this option would respond differently to current disparities in state spending per person on LTC--an important issue for any block-grant option. One variant would take the present pattern of aggregate federal payments to the states for LTC as a starting point. In future years, it would increase the current payment for each state by the rate of growth in expected LTC costs that is implied by the set of capitation payments for different age cohorts. Thus, the formula would determine a pattern of growth in federal payments to the states that would be uniform across states. The formula would not affect the relative share of total federal LTC spending that each state would receive, however. Accordingly, this variant would perpetuate the effects of past disparities in states' LTC spending on federal payments to the states for LTC.

A second variant would in essence apply the capitation rates for different age cohorts uniformly to all states and so would use them to determine the absolute amount paid to each state. This approach could change quite significantly the present pattern of aggregate federal payments to the states because of the different priorities that states currently assign to LTC when allocating their own spending. This approach would base future federal payments on a standard formula that took no account of past levels of a state's financial commitment to LTC. States that had made relatively less effort in the past would receive a larger share of total federal LTC spending than at present, and states that had made relatively greater effort in the past would receive a smaller share of total federal LTC spending than at present.

Under a third variant, the process of determining federal payments to the states on a uniform basis would be phased in, thereby minimizing disruptive shifts in the level of federal funds that states would receive. During a transition period of perhaps 10 years, this approach would calculate the payment to each state in any year as the weighted average of the payments that the state would receive under the first two variants of the option. Over the course of the transition period, the weights applied to the amounts under the first variant would decrease and the weights applied to the amounts under the second variant would increase correspondingly.

As another condition of the grant, states would be required to develop a LTC delivery system to assist people of all ages who needed LTC services. A further federal condition could be that states structure the delivery system around agencies that would each be responsible for allocating a defined level of available program resources among types of service--both residential and nonresidential--and among individuals seeking care. Such a condition would require that services be provided in the most effective combinations to the people judged to be most in need of them. Under this approach, agencies could adapt the various models of assessment and case management to help allocate the available level of program resources among individuals seeking services. Subject to any additional federal conditions, each state could fund its preferred mix of residential and nonresidential services, and could determine who would be eligible for them and how any user charges would be related to privately available resources. A number of states have already developed LTC systems displaying some of these features as part of their efforts to expand the availability of nonresidential LTC services (see Box 1). Broadly similar systems are in place in some Canadian provinces.[7]

Advantages and Disadvantages. A formula-based block grant could equalize the opportunity for people within a state who need LTC services to receive whatever level of needed care the delivery system had resources to provide, without legislatively specifying an entitlement to defined services. The option could result in an integrated LTC system that would build on a model already tried both in a number of states and overseas and that could address the criticism that the present system is fragmented. It would incorporate a predictable ceiling on federal outlays, and possibly on state outlays, and would require that states develop an administrative system designed to allocate the limited resources of a fixed budget fairly among services and among individuals needing LTC. Experience elsewhere suggests that such a system could be both flexible and responsive. This approach would initially require an implicit decision, which would be reflected in the funding formula, about the priority to be accorded LTC in allocating federal resources.

This option, however, could entail large public outlays to meet the needs of people requiring LTC, even though it would not incorporate the open-ended commitment, which Medicaid currently offers, to fund any covered care required by eligible people. States might also prove unable to develop the appropriate administrative systems. In addition, states might fear that, once they had accepted responsibility for developing and administering a LTC system, the formula in federal legislation would be changed and funding levels would be reduced. Moreover, the scope and quality of available care, and any policies relating user

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[7] See R.L. Kane and R.A. Kane, *A Will and A Way* (New York: Columbia University Press, 1985).

BOX 1
State Experience in Reforming Long-Term Care Systems

A 1988 report by the National Governors' Association's Center for Policy Research compared the experience of six states that had reformed their LTC systems by integrating multiple LTC financing and delivery systems and by developing community care systems.[1] (Systems of administration within these states, therefore, should not be considered typical of all states.)

The report found that the states were able to expand the provision of multiple community-based care services--with nonmedical services such as personal care, homemaker, and chore services as their core--by using a systematic process for assessing client needs, authorizing a package of services, and coordinating multiple providers. In the states studied, moreover, some aspects of community care systems--for example, assessment tools, explicit financial eligibility criteria, and system entry channeled through case-management agencies--were tightly structured and uniform statewide but did not compromise the system's ability to respond flexibly to an individual's service needs.

The report also found that states responded administratively in diverse ways to the following common challenges:

- At the state level, an effective continuum of care required a single delivery system supported by multiple funding sources, but linking the separate systems for social services, aging programs, and health care delivery proved very difficult.
- States combined funding from existing sources to finance their program, but found that no single funding source was flexible enough to finance their entire program. Funding from state general revenue funding was essential to fill the gaps.
- At the local level, most states designated a single agency as the client's point of access for receipt of all publicly financed community care programs. The report considered that this made the LTC system less fragmented for clients yet gave states greater control over total program costs. States preferred to hold local LTC systems responsible for end results rather than to control local administration.

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[1] D. Justice, *State Long Term Care Reform: Development of Community Care Systems in Six States* (Washington, D.C.: National Governors' Association, Center for Policy Research, 1988).

charges to privately available resources, could vary from state to state depending on the extent to which national standards were federally mandated.

Furthermore, the experience of six states with LTC reform suggests that designing appropriate program and administrative structures is a challenge.[8] The states appear to have chosen a variety of administrative systems that involve case management without fully exploiting the potential that such systems offer for cost control or quality assurance, once a decision to expand public funding for H&CB care has been made. These choices, unavoidably, were made without access to a comparative evaluation of alternative administrative systems. No information is available from the 1988 study about the effects that the changes had on individuals who sought or received care.

STRATEGY THREE: ESTABLISH SOCIAL INSURANCE PROGRAMS WITH INDIVIDUAL ENTITLEMENTS

This strategy would involve a new social insurance program that provides a legislatively based entitlement to defined LTC services for individuals assessed as having specified functional limitations. Five options that illustrate this approach are considered. One would offer comprehensive coverage--covering both residential and nonresidential forms of LTC throughout an episode of care. The four other options would adopt differing criteria to limit the scope of coverage and thus also to limit the implied increase in federal LTC costs. One option would provide coverage only during an initial period of care ("front-end" coverage), and another would do so only after an initial period of care financed from other sources ("back-end" coverage). A further option would restrict eligibility using an asset threshold set at a level substantially higher than the Medicaid program's asset threshold for single individuals. The remaining option would provide coverage only for nursing home care.

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[8] For an analysis of the experiences of these states, see D. Justice, *State Long Term Care Reform: Development of Community Care Systems in Six States* (Washington, D.C.: National Governors' Association, Center for Policy Research, 1988) and the accompanying box in this chapter. For an interpretation of the results reported in the study, see P. Kemper, "Case Management Agency Systems of Administering Long-Term Care: Evidence from the Channeling Demonstration," *The Gerontologist*, vol. 30, no. 6 (1990), pp. 817-824.

Restricting the duration and kind of care covered and imposing an asset threshold for eligibility are not mutually exclusive alternatives. Although they are not discussed here, options providing back-end or front-end social insurance coverage of nursing home care only and options that would cover nursing home care (but not H&CB care) only for people with assets below a relatively generous threshold are further possibilities that raise few issues not discussed below.

Each option could be designed to cover people of all ages who need care. Alternatively, each could cover a restricted category of people--for example, those aged 65 or older, or those of any age who are eligible for Medicare. If the more restrictive approach were adopted, decisions would be needed on what changes, if any, should be made concerning assistance with LTC costs for those in the excluded category.

Comprehensive Coverage

This option illustrates the most expansive approach to social insurance. It would provide people of all ages with a complete range of LTC services if they met defined standards of functional limitation, and it would finance these benefits through the federal budget.

Description of Option. Providing comprehensive coverage would create a new entitlement to a broad range of defined LTC services, including nursing home care, other forms of residential care, and H&CB care. The entitlement would be based on a person's assessed level of functional limitations. For example, it might extend to people who need human assistance with at least two or three ADLs, people who need constant supervision because cognitive impairments impede their ability to function, and people who need constant supervision because their behavior is often dangerous, disruptive, or difficult to manage. Eligible individuals could either receive covered services from conventionally organized private providers or could enroll in managed-LTC organizations, such as new Social Health Maintenance Organizations (SHMOs) that would be reimbursed under capitation arrangements.

Cost-containment features could include cost-sharing based on a user-charges policy, assessment of functional limitations, case-management or managed-LTC systems, and prospective or capitated payment of providers. Except in the case of care provided through managed-care organizations, however, cost containment could make only limited use of controls on the supply of LTC because LTC services for which people were eligible would be legislatively guaranteed. Legislation and regulations could define quality standards for the program, reimbursement rates could be set at levels that would fund care of this quality and could include case-mix reimbursement, and regulatory mechanisms could be used to enforce the standards.

Advantages and Disadvantages. By creating a new social insurance program, this option would spread the risks associated with access to LTC across the whole population and would thereby provide a very high degree of financial protection against the costs of LTC. By specifying a new entitlement for eligible individuals, the option would protect an individual's access to needed LTC services from the constraining influences of administrative discretion within bureaucratic systems and of budget appropriations that prove insufficient to fund services for all people authorized to receive them. In addition, the financing for the new program could incorporate whatever level of resource-related subsidies reflected the preferred degree of resource redistribution from those with greater resources to those with fewer. This option could also fund a full spectrum of LTC services that are of satisfactory quality.

This approach would integrate not only the financing of LTC, but possibly also its delivery, and would provide all eligible people throughout the country with a similar opportunity to receive needed care. Moreover, it could fund different kinds of LTC service in a consistent way, thereby eliminating the alleged bias toward nursing home care and care for acute conditions that critics perceive in the present system.

The option's major drawback, however, is that total federal LTC outlays would greatly exceed those under current law. More people needing LTC would qualify for federal assistance, and a larger share of the services they received would be federally financed. People would also probably seek more services because of the availability of payment for LTC services by a third party--in this case, the federal government.

Precisely because an individual entitlement would reduce administrative discretion in allocating LTC services and would remove uncertainty about the availability of public funds for LTC, it could make the option's expected cost high.

This increase in demand, moreover, might raise the unit price of all LTC services, at least until service providers commensurately expanded their capacity to meet the demand for care. In the longer term, the program's existence might change attitudes toward the use of formal LTC in ways that would lead to increases in the average quality of care provided, thereby also raising program costs.

A social insurance program covering LTC might also alter decisions about personal saving. In deciding how much to save, people may be influenced by the desire to protect themselves against unpredictable health care costs in old age. To the extent that this desire affects decisions about saving, introducing social insurance arrangements that would provide assured financing for LTC costs could reduce personal saving rates.

Another drawback is that if ADL thresholds were used to assess eligibility, they would have a primary role in determining total spending on the program as well as individual entitlements. ADL measures were developed for research and clinical purposes rather than as administrative criteria for determining entitlement to benefits, and some people seeking expensive LTC services might describe their functional limitations differently to assessors who controlled access to the desired services. This factor could increase to an unknown degree the number of people assessed as eligible for services under the entitlement. The extent of this "assessment creep," however, would depend partly on whether the organization employing the assessors, when determining its priorities, gave greater relative weight to client advocacy or to financial management.

Accordingly, public-sector costs under this strategy would not only be high but would also be subject to significant uncertainty. This uncertainty would be more pronounced for outlays on H&CB care than for outlays on nursing home care, because it is harder to tell for H&CB care both the extent to which a new social insurance program would increase demand and how effectively assessment and managed-care processes could limit such increases.

Furthermore, the availability of managed LTC under the option could be quite limited, at least from SHMOs. In January 1990, only 97 health maintenance organizations (covering about 3 percent of Medicare beneficiaries) were willing to participate in Medicare under risk-sharing arrangements, given the level at which capitation payments were set, and SHMOs would involve more risk for providers than HMOs. In addition, the option would not appeal to those who believe either that the private sector should retain a significant role in LTC financing or that diversity among states in LTC policies is valuable as a source of experimentation and as a reflection of geographic diversity in community values. Finally, people who had already purchased private LTC insurance policies could be expected to object that social insurance would substantially reduce the value of the investments they had made in providing for their own future LTC needs.

"Front-End" and "Back-End" Coverage

One way to constrain total public LTC costs would be to direct subsidies for LTC to groups defined by the duration of their need for services. Among people entering nursing homes, about half stay less than three months and about one-quarter stay more than a year. Those with lengthy stays account for a much larger proportion of days of care than they do of admissions.

Limiting coverage, however, would also suggest the need for a continuing residual welfare program for people unable to afford needed care during the complementary period not covered by social insurance. Such people, for example, might have been denied private LTC insurance coverage, been unable to afford the premiums or copayments, or decided to self-insure and lacked the resources to pay for care they eventually needed.

Description of the Options. The option involving front-end coverage of LTC would differ from the option involving comprehensive coverage by providing public LTC coverage only during an initial period of care (for example, 3 to 6 months), whereas the option involving back-end coverage would provide coverage only after an initial period of care (for example, 12 to 24 months). Private LTC insurance would be available for care during the period not covered. Eligibility for Medicaid, either in its present form or a modified one, would be retained for people needing care during the period not covered by social insurance if this care also was not covered by private risk-pooling arrangements.

Advantages. Providing coverage for the front or back end of care would reduce public costs for the social insurance program to below those under the comprehensive option. By reducing below its present level the maximum duration of care for which private insurance would need to be purchased, a front-end or back-end social insurance program would also make private insurance for the remaining period of care less costly than if no social insurance were available. Taxpayers purchasing such insurance, however, would typically do so out of disposable incomes that had already been reduced by additional tax payments toward the cost of the social insurance program, which implies that the total cost of providing financial protection against all LTC costs would not necessarily be lower than under the option providing comprehensive social insurance coverage.

Front-end coverage would provide financial protection against LTC costs during the initial period of LTC when prospects for rehabilitation are greatest. People would not have to spend down their assets to get needed care in this period, thus facilitating a return to normal community living and possibly avoiding the need for more extended use of LTC. Any LTC services required beyond this initial period appear well suited as a focus for private insurance coverage because exploitation of the availability of insurance benefits (sometimes called "moral hazard") would be a relatively modest problem. Such insurance could be easily characterized for marketing purposes as covering catastrophic LTC costs.

Back-end coverage would provide financial protection against LTC costs during lengthy periods of LTC.[9] This is the type of extended care that is most likely to prove financially catastrophic to the individuals and families concerned. If people knew that financial protection would be available for the costs of lengthy care, those requiring care would probably be more willing to purchase appropriate formal LTC services during the initial period not covered by the social insurance program. Also, by restricting the maximum duration of LTC use that would be left for private insurance to cover, this approach would limit one source of financial risk for insurers, which might facilitate the development of a private insurance market covering the "front end" of care.

Disadvantages. Although both the front-end and back-end approaches to social insurance for LTC would require significantly less federal spending than the approach involving comprehensive coverage, they would still probably involve billions of dollars annually over and above the rapidly growing outlays projected under current law. Cost estimates for both approaches, moreover, like those for the approach involving comprehensive coverage, would entail considerable uncertainty because methods of assessing eligibility, although not well developed yet, would nevertheless have a primary role in determining not only each individual's entitlement but also total spending on the program.

One major disadvantage of the front-end approach is that, even though only a minority of LTC users have very long nursing home stays, the greatest costs for LTC--and hence the greatest presumed need for financial protection--are associated with extended periods of LTC rather than with shorter periods. Another major disadvantage is that it would be difficult to maintain a policy that required assistance to be withdrawn from people who are quite frail or sick when their front-end coverage ran out.

A related disadvantage for people receiving H&CB care from both formal and informal caregivers is that the front-end approach would withdraw financial protection against the costs of an individual's formal LTC when the duration of informal caregiving is becoming extended. This is a time when the demands on the informal caregiver may be growing--for example, because the condition of the care recipient is deteriorating or because the cumulative effect of caregiving demands is generating greater stress for the caregiver. A further drawback of this option--and a major concern of insurers--is that available information on lifetime patterns of LTC use, although increasing, is still quite limited. For insurance companies, which seek to spread risk rather than to bear it themselves, setting insurance premiums for catastrophic coverage is therefore a risky enterprise.

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[9] Some proposals limit coverage for nursing home care in this way but not coverage for H&CB care.

The back-end coverage option, under which private insurers would be expected to cover the initial period of care, would present two challenges for insurers that could limit their willingness to provide coverage at what might be considered "reasonable" rates. One is that, during this initial period, attempts to exploit the availability of private insurance benefits might be greater--and hence, determining who is eligible for benefits could be more difficult--than in the case of catastrophic private LTC insurance. The other is that people might be less willing to purchase such insurance if they thought that the public program might eventually encompass social insurance for short periods of care. Some might also regard as a disadvantage the likelihood that only a minority of nursing home users--and perhaps also of H&CB care users--would receive formal care for long enough to benefit directly from back-end coverage.

Coverage for People with No More Than the Median Level of Assets

A further way to limit the costs of social insurance offering comprehensive coverage would be to restrict eligibility for publicly financed care to people in family units whose assets were no greater than the median level for family units. This option would represent a compromise between providing financial protection against the costs of LTC for all groups in the community, including those with substantial private wealth, and requiring those needing care to become impoverished and to deplete their life savings before qualifying for such financial protection.

Background. In 1984, half of all households headed by people aged 65 or older had assets of at least $60,000. Excluding home equity, half had assets exceeding about $19,000, which is well above Medicaid's asset limit for single individuals.[10] The Pepper Commission's recommendations included a proposal that long-staying nursing home residents be eligible for public coverage if their assets, excluding home equity, are no greater than $30,000 for individuals and $60,000 for couples.[11]

Description of Option. This option would cover the same range of LTC services as the comprehensive social insurance option. It would limit access to public subsidies for those services, however, to people in family units with covered assets that do not exceed a threshold that approximates the median level. The definition of covered assets might include all assets, or it might be limited to all assets other than home equity, or limited further to all liquid assets. Individuals with assets exceeding the threshold might still obtain services through the same LTC delivery system as those with assets below the threshold but they would pay for the full cost of their care. Such individuals could spend down to the asset threshold but, under this social insurance option, would not also be subject to an income test. Separate asset thresholds could be set for single individuals and for married couples, based on the median level of assets for such household units.

Advantages and Disadvantages. This option would appeal to those who believe that LTC financing arrangements should promote a degree of stability in income and assets. At the same time, it would limit the provision of public subsidies to those with above-average levels of assets who have the financial resources to pay for their own care. The option would provide a relatively high degree of financial protection against the costs of LTC for people with a moderate level of assets, and it would presumably eliminate the perception that people would be required to spend down until they become eligible for welfare programs before they could gain public assistance with LTC costs. It would also reduce the disparity between public subsidies that are available for care for acute health conditions and those available for care for chronic conditions. In doing so, it would group the need for LTC with other risks--such as retirement, unemployment, death of a parent, and acute illness--that have become the basis for social insurance programs.

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[10] Bureau of the Census, Current Population Reports, series P-70, no. 7, *Household Wealth and Asset Ownership: 1984* (1986), Table E, p. 4.

[11] This recommendation would represent a significant weakening of the Medicaid program's welfare character, and a partial shift toward a social insurance design. The recommendation would retain the income test for Medicaid eligibility, but would change the asset threshold to one that could be met (according to the commission's report) by three elderly people out of five.

Like other forms of social insurance, however, the option would not appeal to those who believe that the public component of LTC financing arrangements should be means-tested. As discussed in Chapter III, these people would see the option as diverting taxpayers' resources from other uses with greater priority or justification. Although the option might require considerably less additional spending than a social insurance program that offered comprehensive insurance without regard to household wealth, it would significantly raise public LTC costs relative to those under current law. For single people needing LTC, the option would make publicly subsidized care available to individuals whose asset levels are substantially higher than those currently applying under Medicaid. For married people needing LTC, it would also raise public LTC costs in those states where the level of protected assets for a community spouse under Medicaid is below the median asset level that would apply under this option. Finally, the option might cost more because it could make available a broader range of services or services of higher quality than those available under current law.

Coverage for Nursing Home Care Only

Another way to limit the costs associated with social insurance that offers comprehensive coverage would be to restrict the kind of care that the social insurance program would cover.

Description of Option. This option would differ from that involving comprehensive coverage by restricting coverage under the social insurance program to nursing home care only. The need for such care would be determined using medical criteria and a person's assessed level of functional limitations. A complementary referral service could refer people assessed as not requiring nursing home care to organizations that offer care more appropriate to their needs. Medicaid, either in its present form or a modified one, could be retained to provide H&CB care in defined circumstances.

Advantages. This option would provide a high degree of protection against the costs associated with the most expensive form of LTC--nursing home care--and would limit in two ways the additional federal costs associated with a social insurance strategy. First, it would direct assistance to the group that is typically most highly dependent--those requiring nursing home care. In fiscal year 1988, other kinds of care absorbed 25 percent of public expenditures on formal LTC. So, compared with the cost of the comprehensive-coverage option, this option should save at least most of that amount. Second, limiting coverage to nursing home care would forestall the relatively greater increases in demand for H&CB care than for nursing home care that could be expected, for several reasons, to result from the introduction of social insurance for both forms of care.

This option would also create a single funding system for nursing home care and would provide all eligible people throughout the country with a similar opportunity to receive needed care. In addition, the referral system associated with preadmission screening for nursing homes could facilitate the use of more appropriate LTC services for those not requiring nursing home care. This option would also imply a greater role for the private sector in financing H&CB care than would the comprehensive-coverage option. Finally, individuals and their families might be more willing to pay for needed H&CB care if they knew that they would not be at risk later on for substantial nursing home costs as well.

Disadvantages. Although this option would cost less than the comprehensive-coverage option, annual federal LTC outlays would still be billions of dollars higher than those under current law, which are themselves projected to grow rapidly. This approach, moreover, would do nothing to integrate the financing of nursing home care with that for other forms of LTC. Nor would it promote better coordination of their delivery systems.

Limiting coverage to nursing home care would also bias choices within the LTC system away from both H&CB care and forms of residential LTC other than nursing homes. Critics of the present system contend that it already exhibits such a bias. Similarly, the option would do nothing to help informal caregivers who choose not to institutionalize their relatives. Finally, the coverage of H&CB care would remain in the hands of private insurers, although they seem least interested in covering this component of LTC.

CHAPTER VI

AN OVERVIEW OF THE CHOICES

The need for long-term care will grow relatively rapidly over the next few decades. Under current policy and demographic trends, LTC will absorb a growing share of private and public resources. Accordingly, the most fundamental choices for LTC policy are whether the nation should accept this increase and, if so, whether it wants these added resources absorbed in the same pattern and financed in the same manner as occurs today.

THE CURRENT SYSTEM

Current policy on LTC financing is embodied primarily in Medicaid, the major public program funding LTC. Medicaid is implicitly designed to keep income and assets at minimally adequate levels when a person's health status deteriorates. It therefore provides public assistance with LTC costs only after those needing LTC have fully used their own resources (apart from certain exempt ones) in meeting these costs. It also directs funding primarily to nursing home care.

The considerable dissatisfaction with the current LTC system stems from two mutually conflicting perspectives. Fiscal critics of the present system believe that both the level and growth rate of federal LTC costs are unacceptably high and that the private sector should play a larger role in LTC financing to help counteract this pattern. Performance critics of the present system believe that people who need extended LTC services currently have too little financial protection against the catastrophic costs of such care, that a broader range of services should be available, and that the quality of these services should be more uniformly satisfactory. Improving financial protection for people who require extensive LTC services, however, would almost certainly add further to the projected increases in federal LTC expenditures or reduce federal revenue--possibly by large amounts--unless employees were effectively required to purchase group LTC insurance for themselves and their family members. Yet, if nothing is changed in the current system, both fiscal and performance critics will continue to be unhappy; demographics will result in increased costs, but the problems of financial vulnerability and of a bias toward institutional care will remain.

The dissatisfaction that fiscal and performance critics voice suggests that an alternative system might be preferable, if a consensus could be developed on what changes to make and on how to finance them. In that case, a gradual and deliberate transition to the preferred alternative system might be wise. Some people who favor changes in current policy consider that incremental changes, such as those discussed in Chapter IV, are all that is required. Others see incremental changes as stepping stones to more fundamental changes.

ALTERNATIVE STRATEGIES

There are many possible ways to address the issues raised by critics of the current system for financing long-term care. Alternative strategies include some that would address more directly the concerns of fiscal critics and others that focus on those of performance critics. The range of strategies includes:

- Reducing Medicaid's coverage of LTC, through tighter limits on eligibility and benefits or through reductions in reimbursement levels for providers;
- Assigning greater responsibility for LTC to the states;
- Encouraging expansion of the private sector's role in LTC financing; and
- Expanding the public sector's role through social insurance.

Reducing Medicaid's coverage of LTC would respond to the concerns of fiscal critics but not performance critics, whereas expanding the public sector's role would respond to the concerns of performance critics but would certainly increase LTC costs. The other two strategies--transferring responsibility (and a corresponding level of resources) to the states, and encouraging expansion of the private sector's role--each have some potential to address both fiscal and performance concerns, but their success in doing so would be highly dependent on the specific changes made in the system.

Reducing Medicaid's Coverage of Long-Term Care

Restricting Medicaid's LTC benefits, eligibility criteria, or reimbursement levels for providers would unambiguously address the concerns of fiscal critics. A key issue is whether such measures could significantly reduce Medicaid spending without adversely affecting financially vulnerable people to an unacceptable degree. In its mildest form, this strategy could be construed as "leaning against the wind"--seeking to minimize growth in Medicaid outlays through conservative decisions on benefits, eligibility, and reimbursement levels and through incremental program changes such as tightening both estate-recovery processes and program rules requiring people to commit their own resources before Medicaid begins to pay for care.

Assigning Greater Responsibility to the States

Transferring greater responsibility for LTC to the states is a strategy that could be used to achieve more than one objective. One variant of the strategy--simply redefining LTC as a state responsibility--would be particularly effective in reducing federal LTC costs. For example, if current federal spending for LTC were replaced by a block grant to the states that was indexed only for inflation, the growth in federal costs would be significantly below currently projected levels. Although this strategy would address federal LTC costs, it would leave states to deal with all other issues, including new ones raised by the transfer of responsibility.

Another variant, which would also transfer greater responsibility to the states and consolidate current federal spending into a block grant, would retain a role in LTC policy for the federal government and would link growth in federal funding more closely to growth in the need for LTC. This variant could function as a vehicle for implementing one form of the social insurance strategy discussed below.

Encouraging a Greater Private-Sector Role

The strategy of encouraging expansion of the private sector's role in LTC financing through more widespread participation in risk-pooling arrangements under private auspices could be carried out in several ways. These approaches would structure the risk-pooling arrangements differently--for example, using individual insurance, group coverage under employer sponsorship, or insurance that is integrated with the existing system of retirement income and pensions. Most of these approaches, however, would require some form of tax preference to encourage participation in the arrangements.

This strategy could be expected to have different effects on people with different levels of income and assets. People with above-average incomes and assets would be most affected. People with low or moderate levels of income and assets would be less likely to participate in voluntary risk-pooling arrangements for two main reasons. First, LTC insurance would have to compete with necessities such as food and housing when limited incomes were allocated. Second, because they have less income and assets to "spend down," low-income people would face smaller potential out-of-pocket costs if they relied on Medicaid for catastrophic LTC insurance coverage. They would therefore have less to gain from purchasing LTC insurance.

Over several decades, this strategy would gradually raise the proportion of the population who would have the opportunity to obtain renewable LTC insurance coverage. Under voluntary risk-pooling arrangements, people with preexisting conditions implying a need for LTC would not be able to obtain new coverage, although they could renew existing coverage. If, over time, the average age at which people applied for LTC insurance were to fall, then the proportion of applicants denied coverage because of preexisting conditions would be likely to decline and the proportion of the population with insurance coverage could grow. To the extent that this strategy achieved greater participation in risk-pooling arrangements, the additional people who purchased insurance would experience less of the stress that can be associated with lack of financial protection against LTC costs--one of the concerns of performance critics.

No one knows with certainty what level of tax subsidies would be needed to achieve a substantial level of consumer participation. The revenue lost through tax subsidies, however, would almost certainly exceed any Medicaid savings, because the people most likely to respond to tax subsidies for private insurance coverage are also the people least likely to become eligible for Medicaid LTC benefits under current law.

Mandating that employers arrange community-rated group LTC insurance coverage for employees and their family members might be seen as an alternative method to achieve, by compulsion, many of the effects of a social insurance program at considerably less cost to the public sector. Unless employees were required to pay the full cost of the coverage, however, this approach either would entail new subsidies from taxpayers or would increase employers' costs and create new incentives for them to employ fewer people and to shift from full-time to part-time workers. Also, taxpayers might in practice be liable for substantial costs if the arrangements ultimately collapsed.

Expanding the Public Sector's Role

Expanding the role of the public sector by establishing social insurance arrangements to finance LTC could address the concerns of performance critics but would also raise public outlays on LTC substantially above projected levels, thereby exacerbating the concerns of fiscal critics.

This strategy's many variants would differ in certain fundamental aspects. First, the program design could include either comprehensive coverage or limited coverage. In turn, coverage limits could be based on various criteria, used alone or in combination. These criteria include the duration of care (for example, "back-end" versus "front-end" coverage), the type of services covered (for example, nursing home care only), or the level of individual or family resources required for eligibility. Although coverage limits reduce the scope or universality of the benefits provided, they also scale back the resulting increase in public outlays.

Social insurance programs could also differ in two other important attributes:

- Whether benefits would be nationally uniform (as under Medicare) or would vary among the states (as might occur under state-administered programs for which federal and state governments shared financial and policy responsibility); and
- Whether total federal program funding each year would be subject to a ceiling (determined either by a legislatively specified formula or by the annual appropriation process) or would be determined in practice by the cost of providing specified benefits to all qualifying individuals.

Programs with nationally uniform benefits tend to specify entitlements at the level of the individual and to assume that sufficient funding would be provided. Conversely, programs that incorporate a ceiling on public funding for covered services and that require these services to be allocated under stated guidelines are more likely to involve state governments in specifying benefit levels and eligibility conditions and in program administration. Program designs of the former kind could achieve a clearer specification of who is eligible for what benefits, whereas program designs of the latter kind could take advantage of an additional mechanism for containing costs.

What can be said about this strategy's likely outcomes? By varying the specific design of a program, this strategy could achieve any desired increase in financial protection for LTC users and any desired expansion of the scope of covered LTC services, but only by commensurately increasing public LTC outlays. These increases in outlays would be additional to the projected growth in public outlays under current law.

Unlike private LTC insurance markets, which appear subject to market failure in ways that would result in too little coverage, social insurance arrangements could achieve universal coverage, including coverage for people who have preexisting conditions that imply a need for LTC, people who are neither in the labor force nor dependent on someone who is, and people who have low incomes.

The social insurance strategy would change the values embodied in LTC financing policy by eliminating income testing and asset testing of benefits or by reducing their scope. When a person's health status deteriorated, income and assets would remain closer to their earlier levels because this strategy would partly or fully offset the reductions in income and assets that would otherwise occur.

The financing of LTC presents no easy choices. Accordingly, it will be hard to resolve the debate on LTC policy to everyone's satisfaction. The current situation suggests that the problem will continue to command policymakers' attention and that the conflicting pressures for change will become more intense in the years ahead. Nevertheless, there exists a wide range of strategies for restructuring LTC financing in ways that could satisfy, in varying degrees, the views of critics of the current system.

APPENDIX

ESTIMATES OF NATIONAL SPENDING FOR LONG-TERM CARE SERVICES

This appendix, prepared by Actuarial Research Corporation (ARC), presents estimates of national spending for certain long-term care (LTC) services and describes the methods that ARC used to obtain them. The objective is to estimate spending for major LTC services, by type of service and source of funds. These estimates are much in the spirit of the annual estimates of national health care spending published by the Office of the Actuary in the Health Care Financing Administration (HCFA), although the services included differ from HCFA's estimates as discussed later.

NURSING HOMES

Fiscal year 1988 was chosen as the base year because it is relatively recent and some supporting documentation is now available. Also, expenditures for more recent years are increasingly subject to revision, especially in programs like Medicare that use accrual accounting.

The estimate of total nursing home expenditures for fiscal year 1988 is derived directly from the HCFA national health expenditure estimates for nursing homes. The HCFA estimate includes a subdivision of expenditures by source of funds. The HCFA estimate of nursing home costs is believed to be reliable for expenditures on the types of institutional services addressed in this report. The estimate is intended to match the universe of homes included in the National Nursing Home Survey (NNHS) plus Medicaid-certified intermediate care facilities for mentally retarded people (ICF-MRs). The NNHS sampling frame is specifically intended to exclude homes providing room and board services only and homes serving only one health problem, such as ICF-MRs. The HCFA estimate for nursing homes excludes the 40 percent of ICF-MR expenditures that are reported as part of hospital expenses. These expenditures have been included with nursing home expenses in the estimates described here.

Total estimated nursing home expenditures in fiscal year 1988 were $44.3 billion (see Table A-1). Of this amount, $20.2 billion was paid out of pocket, $20.9 billion was paid by Medicaid, and small amounts were from other payers.

The average daily census in nursing homes in 1988 was 1.5 million. This estimate is based on a HCFA projection of nursing home beds, assuming an average occupancy rate of 95 percent. The concept of "average daily census" (ADC) is important to the approach used in this study. Because the number of nursing home residents is believed to change gradually over time, the ADC is the number of residents one would expect to find at midyear. The ADC in nursing homes is considerably smaller than the number of people who spend some time in a nursing home in a year, because many nursing home stays are short. In the NNHS, the number of residents at a point in time (approximately the ADC) is provided by the "Residents Survey" portion of the survey. This is supplemented by the "Discharge Survey," which is the number of discharges during the year. One way to visualize how these surveys complement each other is to assume that the Residents Survey is taken on the last day of the year and represents the number of people in nursing homes on that day. The Discharge Survey represents people who were in a nursing home during the year but were discharged before the last day. So the sum of the two--residents plus discharges--is the total number of users during the year. The NNHS shows that the total number of people using nursing home services during the year is about 82 percent higher than the number of residents at a point in time. This ratio is generally larger for younger age groups, whose stays are shorter. It is also larger for Medicare-covered stays, because Medicare only pays for acute care use of nursing homes.

The ADC is used as the utilization index here because it is easier to work with analytically. The total number of nursing home days can be calculated by multiplying the ADC by the number of days in the year. This measure captures all use regardless of length of stay.

TABLE A-1. ESTIMATED TOTAL SPENDING ON NURSING HOME SERVICES FOR ALL AGE GROUPS, BY NURSING HOME'S TYPE OF CERTIFICATION AND BY SOURCE OF PAYMENT, FISCAL YEAR 1988

	Skilled Nursing Facility	Skilled Nursing Facility/ Intermediate Care Facility	Intermediate Care Facility	Intermediate Care Facility for Mentally Retarded People	Other	Total
In Millions of Dollars						
Federal						
Medicare	410	470	6	0	0	886
Medicaid	2,130	4,370	1,765	3,238	15	11,518
VA and other	70	626	134	0	96	927
State and Local						
Medicaid	1,743	3,575	1,444	2,650	12	9,424
Other	6	10	7	0	20	43
Private						
Out of pocket	4,259	9,122	4,204	0	2,606	20,191
Other private	530	436	55	0	248	1,269
Total	9,148	18,609	7,615	5,888	2,997	44,258
As a Percentage of All Spending on the Type of Care						
Federal						
Medicare	4.5	2.5	0	0	0	2.0
Medicaid	23.3	23.5	9.5	17.4	0.1	26.0
VA and other	0.8	3.4	0.7	0	0.5	2.1
State and Local						
Medicaid	19.1	19.2	7.8	14.2	0.1	21.3
Other	0.1	0.1	0	0	0.1	0.1
Private						
Out of pocket	46.6	49.0	22.6	0	14.0	45.6
Other private	5.8	2.3	0.3	0	1.3	2.9
Total	100.0	100.0	100.0	100.0	100.0	100.0

SOURCE: Congressional Budget Office preliminary calculations based on estimates compiled by Actuarial Research Corporation.

NOTE: VA = Department of Veterans Affairs.

Partitioning expenditures among payers is also easier using the ADC. If the average daily census is considered as equivalent to use on any given day, in most cases there will be a single payer for that day of care. For the largest sources of payments (Medicaid and private out-of-pocket spending) services are generally paid for sequentially--first out of pocket and then by Medicaid. Some people enter the nursing home eligible for Medicaid and have all of their expenses paid by Medicaid. Others enter as private payers and eventually spend down their incomes and resources to the Medicaid eligibility levels. Medicare presents a minor problem in that Medicare patients will be paying the copayment from other sources (out of pocket, private Medigap insurance, or Medicaid). This minor inconsistency appears to be greatly outweighed by the advantages of assigning all costs to the primary payer on any given day in the year.

Another reason for choosing to assign costs based on the primary payer is the quality of data available for the primary payer. The information on multiple payers is missing for a large number of users in the NNHS. Assigning costs based on all payers over the year would require that results with a large degree of uncertainty be imputed to the cases with missing data.

The general approach, then, is to take the HCFA estimates of nursing home costs, exclusive of ICF-MR costs, and use the NNHS to allocate these costs by more detailed characteristics of the users based on the NNHS residents survey. All ICF-MR costs are paid by Medicaid.

The NNHS residents survey data released for public use were edited in minor ways to make them agree with published data. This editing consisted mainly of reassigning nursing homes' levels of certification to match published data (apparently the certification level of one large home in the survey was listed as unknown in the public use version of the survey). The survey weights were then adjusted so that the total average daily census would match the number derived from the HCFA estimate of nursing home beds. Small adjustments were made in the allocation of residents to primary payer by further adjusting these weights by small amounts. This adjustment affected mostly the minor payers, "other federal" and "other state and local."

The reallocation was deemed necessary to make the average costs per resident reasonable for those minor payers.

Nursing home charges for the primary payer were then adjusted so that they would match, in aggregate, HCFA's estimate of the payments made by each payer. A small extract of the modified file was then prepared. The extract includes age, sex, marital status, primary payer, ADL and IADL status, and modified monthly charge. This file was tabulated to produce Table A-1, except for the ICF-MR column, which was added independently.

HOME- AND COMMUNITY-BASED SERVICES

In estimating expenditures on home- and community-based (H&CB) services associated with acute and long-term care, the primary problem is that very few data are available for payers other than Medicare and Medicaid. Moreover, there is disagreement even on which services should be included in such an estimate.

HCFA now provides estimates of home health care as a separate category in its national health expenditure publications. The HCFA estimate includes Medicare expenditures, Medicaid expenditures, and an amount attributed to other payers that is estimated from the proportion of expenses on the Medicare home health cost reports that are paid by Medicare. These reports suggest that Medicare pays for about half the services provided by home health agencies that participate in Medicare.

The HCFA estimates thus include all H&CB services paid by Medicaid, whether for acute or long-term care, and acute services provided by Medicare participating providers. These estimates probably significantly understate the universe of home- and community-based services. In particular, some home health agencies do not participate in Medicare, and there are undoubtedly also services provided by nurses and other people not associated with an agency. HCFA does not include LTC services provided in the home or community unless Medicaid pays for them. A review of the data sources described below suggests that Medicaid pays for only a small share of those services.

Table A-2 summarizes the spending estimates for home- and community-based services. The services may be grouped into "medical" and "other" services. Medical services are those services that Medicare would pay for if they were provided to a Medicare-eligible person within the scope and duration of the Medicare benefit and if the

TABLE A-2. ESTIMATED TOTAL SPENDING ON HOME- AND COMMUNITY-BASED SERVICES FOR ALL AGE GROUPS, BY TYPE OF SERVICE AND PAYMENT SOURCE, FISCAL YEAR 1988

	Nursing	Home Health Aide Services	Physical Therapy	Speech Therapy	Other Therapy	Medical Social Services
			In Millions of Dollars			
Federal						
Medicare	1,329	638	303	30	34	40
Medicaid	151	377	22	2	3	9
Other	152	130	4	0	0	4
State and Local						
Medicaid	124	308	18	2	2	7
Other	4	571	3	0	2	12
Private						
Out of Pocket	3,085	519	20	2	0	1
Health insurance	162	26	29	3	3	6
Other	51	26	4	0	0	1
Total	5,058	2,594	404	41	46	79
			As a Percentage of All Spending on the Type of Care			
Federal						
Medicare	26.3	24.6	75.1	75.0	75.5	50.2
Medicaid	3.0	14.5	5.4	5.4	6.0	11.2
Other	3.0	5.0	1.0	1.0	1.0	5.0
State and Local						
Medicaid	2.4	11.9	4.5	4.4	4.9	9.1
Other	0.1	22.0	0.8	0.9	3.3	15.3
Private						
Out of Pocket	61.0	20.0	5.0	5.0	1.0	1.0
Health insurance	3.2	1.0	7.2	7.2	7.2	7.2
Other	1.0	1.0	1.0	1.0	1.0	1.0
Total	100.0	100.0	100.0	100.0	100.0	100.0

(Continued)

recipient were judged to need the services within the Medicare regulations. Medical services include nursing, home health aide, therapy, and medical social services. Other services are those not covered by Medicare.

TABLE A-2. Continued

Home-Delivered Meals	Center-Based Meals	Homemaker Services	Adult Day Care	Senior Center	Transportation	Total
			In Millions of Dollars			
0	0	0	0	0	0	2,375
25	61	568	51	50	30	1,349
120	488	125	30	183	14	1,249
20	50	463	42	40	24	1,101
55	279	339	56	94	96	1,509
140	49	747	89	367	82	5,102
0	0	0	0	0	0	229
40	49	249	30	183	27	660
401	975	2,491	296	917	274	13,574
			As a Percentage of All Spending on the Type of Care			
0	0	0	0.0	0	0	17.5
6.3	6.3	22.8	17.1	5.4	11.0	9.9
30	50	5.0	10.0	20.0	5.0	9.2
5.1	5.1	18.6	14.1	4.4	8.9	8.1
13.6	28.6	13.6	18.8	10.2	35.1	11.1
35.0	5.0	30.0	30.0	40.0	30.0	37.6
0	0	0	0	0	0	1.7
10.0	5.0	10.0	10.0	20.0	10.0	4.9
100.0	100.0	100.0	100.0	100.0	100.0	100.0

SOURCE: Congressional Budget Office preliminary calculations based on estimates compiled by Actuarial Research Corporation.

The Medicare payment amount, $2.4 billion, is the HCFA estimate of payments under Part A and Part B of Medicare in fiscal year 1988. These estimates are on an annual basis and are subject to revision as additional data accumulate. The data are based on both interim payments to home health agencies and on final settlements paid after cost reports are submitted. The process of settling costs in many cases takes years to complete, so it adds another degree of uncertainty to what the final estimates will be. Again, 1988 was chosen as a base year so that the data would be nearly complete and revisions would likely be small.

The general estimation strategy is to build on the Medicare cost, as this is the most reliable source of information on spending for home health care. The Medicare expenditures on home health services are first split by type of service using a distribution based on Medicare billing data. The results are then inflated to the total universe of spending based on data from the 1979 and 1980 Health Interview Survey (HIS) supplements on home care. Those surveys asked the interviewees about the frequency of use of services provided by a nurse and by other health workers in the two weeks before the interview. They also reported who was paying for the services. Unfortunately, there are a large number of nonrespondents to these questions, and it is unknown whether the nonrespondents have the same distribution as the respondents. The data are also somewhat old, and some changes have occurred in Medicare that might affect the results before 1988, although the Medicare trends suggest any such effects are probably minor. Nonetheless, these data appear to be the best available for the purpose.

The 1979 and 1980 HIS data were used to estimate the proportion of visits in the past two weeks paid by Medicare. Medicare paid for an estimated 30 percent of visits by nurses and 25 percent of visits by other health workers. These factors were used to inflate the Medicare expenditures for nursing visits and for home health aide visits, respectively. Medicare has no copayment for home health services, but its payment rates for home health services are subject to ceilings. Consequently, Medicare's total payments for these services are below the total amount that providers would normally charge for them. HCFA data suggest that Medicare pays 79.3 percent of charges. Medicaid probably receives an even greater discount, although there appear to be no data on this. The estimates assume that Medicaid pays 60 percent of charges. They further assume that the difference between charges and reimbursement is not paid by any other payer. These assumptions result in estimated spending from all payment sources of $5.1 billion for nursing care in the home and $2.6 billion for home health aide services.

A similar procedure was used to estimate the spending for physical, speech, and other therapies using data from the 1982-1984 Long-Term Care Surveys of Medicare beneficiaries. It appears that Medicare pays a much higher proportion of costs for these services. Although the Long-Term Care Survey does not include people ineligible for Medicare, the number of non-Medicare recipients of therapy services in the home is probably small. The assumption that Medicare pays 50 percent of medical social service visits is merely conjecture. Fortunately, the volume of such services is small.

The allocation of expenditures to sources of payment is based largely on Medicare and Medicaid data, the 1979-1980 HIS home care supplement data, the 1982-1984 Long-Term Care Survey, and HCFA's distribution of its home health spending estimates by source of payment.

Other Services

The estimates of spending for certain other LTC services provided in the home and community are based primarily on utilization data from the 1984-1986 Health Interview Survey Longitudinal Study on Aging (LSOA) and available estimates of the relative prices of services. The LSOA was used to provide multipliers for relative use of those other services compared with home health aide services that are also covered by this survey. Use of home health aide services therefore provides the link between the estimates of "medical" services and "other" services in Table A-2.

The survey provides the number of people reporting use of a service in the past year and a judgment by the respondent of whether the service was used frequently, sometimes, or rarely. The responses were used only to estimate how frequently the services were used relative to use of home health aide services. Arbitrary weights were assigned to the responses: those reporting use of a service "sometimes" were assumed to have half the use of "frequent" users; "rare" users were assumed to have one-fourth the use of frequent users. Experimenting with alternate weighting schemes showed that the results were not very sensitive to the particular weights used. After considering the proportion of people using each service and the relative use of the service, it was estimated, for example, that there are 1.03 times as many home-delivered meals as there are home health aide visits, 3.76 times as many meals at senior centers, and 0.96 times as many homemaker visits.

These estimated proportions and estimates of prices per service, relative to the price of a home health aide's visit, were combined to estimate the total spending for each of the other services compared with the spending for home health aide services. For example, home-delivered meals are estimated to equal 1.03 x 0.15 x $2.594 billion, or $401 million. (This calculation assumes that the price of a home-delivered meal was 15 percent of the price of a home health aide's visit.) The need to use such indirect methods to estimate even the current use of home- and community-based services emphasizes the problem that policymakers have in assessing the need for, and access to, such services.

Allocation of expenditures to specific payers was based on bits of information from several sources. Some information is available from Medicaid on home- and community-based waivers and personal care expenditures, although little is known about the amount spent for specific services within these programs. The LSOA indicates whether recipients of these services had Medicaid coverage but not whether Medicaid was the payer. Some data are also available from the Department of Veterans Affairs and for programs funded under Title III of the Older Americans Act and Title XX of the Social Security Act. These suggestive pieces of information were used to estimate an approximate distribution of expenditure by payer.